



Division of Aging

Home and Community-Based Services Waiver Provider Manual

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Table of Contents

Table of Contents	v
Section 1: Introduction	1-1
Overview	1-1
Indiana Health Coverage Programs Waiver Provider Responsibilities	1-1
Provider Responsibilities Specific to the Waiver Program.....	1-2
Waiver Provider Application and Certification	1-2
Waiver Provider Enrollment.....	1-3
Helpful Tips for Completing the IHCP Enrollment Application	1-4
Waiver Provider Information Updates.....	1-4
Section 2: Claims and Billing	2-1
Overview	2-1
Eligibility for HCBS Waiver Services Affects Billing.....	2-1
Waiver Authorization	2-1
Billing Instructions	2-1
Claim Tips and Reminders	2-2
Claim Voids and Replacements.....	2-2
Division of Aging HCBS Waiver Rates	2-3
Section 3: Quality Assurance /Quality Improvement	3-1
Quality Monitoring	3-1
Incident Reporting.....	3-1
Complaint Resolution.....	3-2
Mortality Review	3-2
Quality Reviews	3-3
QIS Process	3-3
Section 4: Financial Oversight	4-1
Waiver Audits.....	4-1
FSSA Audit Oversight.....	4-1
Medicaid Fraud Control Audit Overview	4-1
Section 5: Division of Aging Waivers	5-1
Overview	5-1
Level of Care (LOC)	5-1
Aged & Disabled Waiver	5-1
Traumatic Brain Injury Waiver (TBI)	5-2
Section 6: Case Management	6-1
For Aged & Disabled and Traumatic Brain Injury Waivers	6-1
Case Management Monitoring Standards.....	6-2
Section 7: Service Definitions	7-1
Service Definition Overview	7-1
Adult Day Services.....	7-1
Adult Family Care	7-4
Assisted Living.....	7-8
Attendant Care.....	7-10
Behavior Management/Behavior Program and Counseling	7-13
Case Management	7-15
Community Transition.....	7-19
Environmental Modifications	7-21
Environmental Modification Assessment.....	7-26

Healthcare Coordination	7-28
Home-Delivered Meals	7-30
Homemaker Services	7-32
Nutritional Supplements	7-34
Personal Emergency Response System	7-36
Pest Control	7-38
Residential-Based Habilitation	7-40
Respite Services	7-42
Specialized Medical Equipment and Supplies	7-44
Structured Day Program	7-48
Structured Family Caregiving	7-50
Supported Employment	7-53
Transportation	7-55
Vehicle Modifications	7-57
Section 8: Provider Help	8-1
Insite Communication Instructions	8-1
Helpful Websites	8-1
Helpful Contact Numbers	8-1
Communications	8-3

Section 1: Introduction

Overview

Section 1915(c) of the *Social Security Act* permits states to offer, under a waiver of statutory requirements, an array of Home and Community-Based Services (HCBS) that an individual needs to avoid institutionalization. These programs allow the state of Indiana's Medicaid program to provide services that would ordinarily be provided only in an institution to be provided in an individual's home or other community setting. Individuals must qualify for institutional care to be eligible for home and community-based services. The term waiver refers to waiving of certain federal requirements that otherwise apply to Medicaid program services. For example, home and community-based services or "waivers" are not Medicaid entitlement programs.

The Family and Social Services Administration (FSSA) has overall responsibility for the waiver programs; day-to-day administration and operation of individual waiver programs is delegated to divisions within FSSA. The Division of Aging (DA) offers two waiver programs:

- The Aged & Disabled (A&D) waiver
- The Traumatic Brain Injury (TBI) waiver

This manual provides a primary reference for the A&D and TBI waiver providers. This manual provides instruction to case managers, other service providers, State staff, family members, advocates, and waiver participants, and is available to assist all those who administer, manage, and participate in the A&D and TBI waiver programs. The information and direction in this manual replaces all previous waiver manuals. Current waiver requirements can be found in the approved waiver applications and the Aging Rule 455 IAC 2.

Individuals and their families may find additional information courtesy of the Indiana [Governor's Council for People with Disabilities](http://in.gov/gpcpd) at in.gov/gpcpd.

Indiana Health Coverage Programs Waiver Provider Responsibilities

IHCP Provider Agreement

Waiver providers are enrolled in the Indiana Health Coverage Programs (IHCP) and have executed an *IHCP Provider Agreement* with the FSSA. This agreement states that the provider will comply, on a continuing basis, with all the federal and State statutes and regulations pertaining to the IHCP, including the waiver programs' rules and regulations. Forms are available on the [Forms](#) page at indianamedicaid.com. By signing the agreement, the provider agrees to follow the information provided in the *IHCP Provider Manual*, as amended periodically, and the *Division of Aging Home and Community-Based Services Waiver Provider Manual*, as amended periodically, as well as all provider bulletins, banners, and notices. All amendments to the *IHCP Provider Manual*, the *Division of Aging Home and Community-Based Services Waiver Provider Manual*, and all applicable Indiana Administrative Codes (IACs), Rules, and Regulations are binding on publication. The *Division of Aging Home and Community-Based Services Waiver Provider Manual* and all publications are available online on the [Manuals](#) page at indianamedicaid.com.

Provider Record Updates

To ensure timely communication of all information, providers must notify the FSSA and its fiscal agent when enrollment record information changes. Provider information is stored in two systems: IndianaAIM and INsite. IndianaAIM is maintained by the fiscal agent, and INsite is maintained by the FSSA.

IndianaAIM is the Medicaid Management Information System (MMIS). The fiscal agent is responsible for maintaining IndianaAIM; therefore, the fiscal agent must have accurate “pay to,” “mail to,” and service location information on file for all providers. It is the provider’s responsibility to ensure that the information on file with the fiscal agent is correct. Providers are required to submit address and telephone change information to the fiscal agent within 10 days of any change. If the provider is licensed through the Indiana State Department of Health, the provider must also notify the Indiana State Department of Health of any changes to the provider’s name, address, or telephone number. Forms are available on the [Forms](#) page at indianamedicaid.com.

INsite is the system that stores client eligibility information along with the client’s service plans, Notice of Actions (NOAs), level of care (LOC) information, and case notes entered by the case managers for individual clients. INsite also has a provider database that is maintained by Division of Aging staff and is intended to provide up-to-date information about the certification status of waiver providers. Provider selection profiles (pick lists) are generated from INsite; therefore, it is very important that the information listed in INsite is the most current and up-to-date information available. Provider information changes must be made by contacting the waiver/provider analyst, Indiana Health Coverage Programs (IHCP), at Daproviderapp@fssa.in.gov.

Provider Responsibilities Specific to the Waiver Program

Providers must understand the service definitions and parameters for each service authorized on the NOA. All waiver providers are subject to audit and potential recoupment if the services provided are not in agreement with the services authorized as indicated on the approved NOA. If the needs of a waiver participant change, the provider must contact the case manager to discuss revising the service plan.

If a service can be funded under the State Plan or Medicaid waiver, it is the provider’s responsibility to seek State Plan prior authorization before the service is requested as a Medicaid waiver service. Documentation of an appropriate prior authorization (PA) denial is required before the service is approved under waiver. An appropriate PA denial must be related to the actual service and not related to the PA process. For example, a PA denial with the reason *provider did not submit required documentation* would not be considered an appropriate PA denial.

Pursuant to the signed provider agreement, providers are required to furnish at least 30 days’ written notice before terminating waiver services to an individual. This notice must be made to the individual, the legal representative if applicable, the individual’s case manager, and the Division of Aging.

Waiver Provider Application and Certification

Becoming a waiver provider begins with the FSSA/DA certification process and is finalized with the IHCP provider enrollment process. The DA must certify providers of the A&D and TBI waivers. Applicants must complete the certification process through the DA and the IHCP enrollment process through the fiscal intermediary (HP).

- Effective July 14, 2014, a revised application for provider certification became available. To eliminate duplication, the provider application has been streamlined from five pages to one. The revised application is an interactive document that can be completed electronically.
- An information and application packet (with accompanying required documents) is available on the DA website's [Medicaid Waivers](http://in.gov/fssa/da/3476.htm) page at in.gov/fssa/da/3476.htm.

Prospective applicants are encouraged to submit application packets via email; however, paper applications continue to be accepted. Please submit certification applications, updates, or terminations to the following addresses:

Email: Daproviderapp@fssa.in.gov

or

Mail: **ATTN: Waiver/Provider Analyst**
Family and Social Services Administration
Indiana Health Coverage Programs (IHCP)
DA Home and Community-Based Services Waivers
402 West Washington Street, Room W382, MS 07
P.O. Box 7083
Indianapolis, Indiana 46207-7083

Phone: 317-232-4650

Applicants and current providers are also encouraged to contact their local Area Agency on Aging (AAA) for questions concerning FSSA DA waiver services. A list of current AAAs is located on the [Area Agencies on Aging](http://in.gov/fssa/da/3478.htm) webpage at in.gov/fssa/da/3478.htm.

- When a completed application is received, it is date stamped and reviewed by the Waiver/Provider Analyst and the Division of Aging staff.
- If additional information is needed, applicants may be contacted via email or telephone with a request for additional information. A 30-day time frame is given for submission of additional information. If the necessary documentation is not submitted in a timely manner, the application may be returned with the request to resubmit.
- If information is sufficient and meets the requirements for specific services, the provider is certified for those requested services.
- Preliminary information is entered into the waiver provider database and the Waiver/Provider Analyst sends the provider a *Waiver Service Certification Letter*.
- The *Waiver Service Certification Letter* directs the provider to contact the fiscal intermediary (HP) to complete the IHCP provider enrollment process. The applicant is instructed to attach a copy of the DA waiver certification to the IHCP application for processing. Providers may begin providing services when they:
 - Receive their HP billing number
 - Are activated in the waiver provider database
 - Receive a Notice of Action (NOA)

Waiver Provider Enrollment

After a prospective provider receives the DA *Waiver Service Certification Letter*, the enrollment process with the IHCP begins. **The enrollment application MUST be submitted within 90 days of certification.**

- A prospective provider may obtain an *IHCP Provider Enrollment Application* by downloading it from the [Provider Enrollment page](http://indianamedicaid.com) at indianamedicaid.com, or by contacting 1-877-707-5750 to request an application by mail.

- Prospective providers must complete the enrollment application form and submit the completed application form along with the *Waiver Service Certification Letter* to the following address:

**Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263**

Helpful Tips for Completing the IHCP Enrollment Application

The application form asks the provider to choose a business structure. As a waiver provider, you are enrolled as a sole practitioner (billing provider), or a group (a group must have members linked to the group). The members linked to the group are called *rendering providers* and are enrolled as rendering providers linked to the group. Rendering providers cannot bill for services; the group bills for services, identifying the rendering provider as the performer of the service. To be a group with members, all of the members must be certified by the DA.

Each prospective provider must designate a “type” and “specialty.” The IHCP provider type for HCBS waiver providers is 32 (Waiver). The specialties the provider chooses must be the ones it is certified by the Division of Aging (DA) to provide, and DA certifies services for the following:

- 350 – Aged & Disabled Waiver (AD)
- 356 – Traumatic Brain Injury Waiver (TBI)

The enrollment application must be signed and submitted with the requested documentation, including form W-9; electronic funds transfer (EFT) form; and a copy of the *Waiver Service Certification Letter*.

All enrollment forms must be directed to the Provider Enrollment address listed previously (address is also listed on the application form) to ensure proper processing.

Enrollment documents are logged into a document tracking system and issued a document tracking number.

Provider Enrollment has a dedicated staff member assigned to coordinate and handle all waiver provider enrollments and updates. This staff member works closely with the DA to ensure timely and accurate maintenance of waiver files.

The staff member reviews the enrollment packet to ensure completeness according to the Provider Enrollment guidelines and enter the provider’s information into IndianaAIM. A provider letter is generated and sent to the provider detailing the assigned IHCP provider billing number and enrollment information entered into IndianaAIM. Providers are encouraged to review this letter to ensure enrollment accuracy.

If the packet needs correcting or is missing required documentation, the HP Provider Enrollment Unit will contact the applicant by telephone, email, fax, or mail. This contact is intended to communicate what needs to be corrected, completed, and submitted before the IHCP can process the enrollment transaction.

Waiver Provider Information Updates

Updates to the following information must be submitted within 10 days of the change to the waiver/provider analyst at Daproviderapp@fssa.in.gov or (317) 232-4650:

- Name changes
- Tax identification changes

- Additional service locations (additional service location addresses)
 - Requires new DA Waiver Service Certification
- Changes to counties served
- Specialty changes (all specialties must be certified by the FSSA)
 - Requires new DA Waiver Service Certification
- Changes in ownership (CHOW)
 - Requires new DA Waiver Provider Application
 - Requires new DA Waiver Service Certification

After update certification requirements for the provider have been met, the Division of Aging sends a new *Waiver Service Certification Letter* to the provider detailing the approved services and instructing the provider to begin the update process with HP, the IHCP fiscal agent. The HP Provider Enrollment staff member works closely with the DA to complete and maintain provider enrollment information.

Providers are required to obtain an *IHCP Provider Enrollment Update Form* on the [Provider Enrollment page](#) at indianamedicaid.com or by contacting the Provider Enrollment helpline at 1-877-707-5750 to request the update form. Providers must complete the update form with appropriate signature and submit the form along with the waiver certification letter to the following address:

Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263

Updates for the following information must be submitted to the IHCP Provider Enrollment Unit:

- Name changes
- Tax identification changes
- Additional service locations (additional Service Location Addresses)
 - Requires a copy of the new DA Waiver Service Certification Letter
- Specialty changes (all specialties must be certified by the FSSA)
 - Requires a copy of the new DA Waiver Service Certification Letter
- Changes in ownership (CHOW)
 - Requires a copy of the new DA Waiver Service Certification Letter

The IHCP Provider Enrollment analyst reviews the update form and documents to ensure completeness according to the Provider Enrollment guidelines, and updates the provider's information in IndianaAIM. An automated provider letter is generated, detailing the changes made to the enrollment record. Providers are encouraged to review this letter to ensure enrollment accuracy.

All questions regarding the status of the waiver provider's enrollment or updates can be directed to the Provider Enrollment helpline at 1-877-707-5750.

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Section 2: Claims and Billing

Overview

The Family and Social Services Administration (FSSA) has overall responsibility for the waiver programs; day-to-day administration and operation of individual waiver programs is delegated to divisions within the FSSA.

Eligibility for HCBS Waiver Services Affects Billing

All potential waiver members must enroll in the Indiana Health Coverage Programs (IHCP). At this time, waiver participants may not be enrolled in managed care. To be eligible for reimbursement for waiver services, the waiver member must have an open waiver level of care status in IndianaAIM. All service providers must verify IHCP eligibility for each member before initiating services.

The Area Agencies on Aging (AAA) are the entry points for the Aged & Disabled and Traumatic Brain Injury waivers. Initial eligibility (level of care) is determined by the entry point agencies. Before the level of care is recorded in IndianaAIM, the level of care and the initial service plan must be approved and a start date established. The level of care segment with the start date is then entered into IndianaAIM by the Division of Aging (DA).

Note: The fiscal agent cannot add or correct a waiver level of care segment in IndianaAIM nor terminate a managed care enrollment.

Waiver Authorization

The waiver case manager is responsible for completing the service plan, which results in an approved Notice of Action (NOA). The NOA details the services and number of units to be provided, the name of the authorized provider, and the approved billing code with the appropriate modifiers. The case manager transmits this information to the waiver database, INsite. INsite communicates this data to IndianaAIM, where it is stored in the prior authorization database. Claims deny if no authorization exists in the database or if a code other than the approved code is billed. Providers are not to render or bill services without an approved NOA. It is the provider's responsibility to contact the case manager if there is any discrepancy in the services authorized or rendered and the approved NOA.

Billing Instructions

Home and Community-Based Services (HCBS) waiver claims are billed on the paper CMS-1500 claim form or via the 837P electronic transaction. Web interChange is an interactive web application that allows providers to access IndianaAIM through the Internet. Web interChange is fast, free, and does not require special software. The CMS-1500 form is available on the [Forms](#) page at indianamedicaid.com. Instructions for completing the form are located in the [IHCP Provider Manual](#). Providers bill services based on an approved NOA, using an appropriate procedure code and the pricing method associated with the procedure code, such as per unit, per day, or per month. Additional pricing information is available on the [Fee Schedule](#) at indianamedicaid.com. General guidelines include:

- Do not bill for services before they are provided.

- If a unit of service equals 15 minutes, a minimum of eight minutes must be provided to bill for one unit.
- Activities requiring less than eight minutes may be accrued to the end of that date of service.
- At the end of the day, partial units may be rounded as follows: units totaling eight or more minutes may be rounded up and billed as one unit.
- Partial units totaling less than eight minutes may not be billed.
- Monthly units are billed at the end of the month.
- Daily units may be billed daily, weekly, or monthly.

Note: If a waiver member is temporarily in an institutional setting, a provider may not render nor be reimbursed for waiver services during that time.

Claim Tips and Reminders

When billing Medicaid waiver claims, the provider must consider the following:

- The IHCP does not reimburse time spent by office staff billing claims.
- Providers may bill only for services authorized on an approved NOA.
- A claim should include dates of service within the same month. Do not submit a claim with dates of service that span more than one month on the same claim.
- The units of service as billed to the IHCP must be substantiated by documentation in accordance with the appropriate *Indiana Administrative Code* (IAC) regulations and the waiver documentation standards issued by the FSSA.
- Services billed to the IHCP must meet the service definitions and parameters as published in the aforementioned rules and standards.
- Updated information is disseminated through IHCP provider bulletins, which is available on the [Bulletins](#) page at indianamedicaid.com and DA bulletins (sent via email and posted on the State agency websites). Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices.

See the *IHCP Provider Manual* for instructions about how to complete the paper *CMS-1500* claim form. In addition, the fiscal agent and the FSSA recommend submitting claims electronically. Providers may submit claims electronically using Web interChange. For information about Web interChange, please see [indianamedicaid.com](#) or contact Provider Assistance. Telephone numbers are available on the [IHCP Quick Reference](#), which is available on the [Contact Us](#) page at [indianamedicaid.com](#).

Claim Voids and Replacements

If a paid or denied claim must be adjusted (replaced), the initial claim is voided and a new claim takes the place of the old claim. If the claim was paid before the adjustment was made, any money paid is recouped by setting up an accounts receivable (A/R) for the amount of the recoupment, which is identified on the Remittance Advice (RA).

The *CMS-1500* adjustment form is available on the [Forms](#) page at [indianamedicaid.com](#). Instructions for completing the form are located in the [IHCP Provider Manual](#).

Division of Aging HCBS Waiver Rates

The following table identifies procedure codes and modifiers, the waivers for which the service is available, and the payment methodology associated with the procedure code.

Table 2.1 – Division of Aging HCBS Waiver Rates as of 5/01/14

INsite Code	Service	Price Code	Mod 1	Mod 2	Mod 3	Dsc Proc Modified	A&D 127	TB 131	Notes
ADST	Adult Day Service Transportation	T2003	U7			U7=WAIVER	\$18.19	\$17.06	Per Trip
AL1	Assist Living Waiver/Diem	T2031	U7	U1		U7=WAIVER U1=LEVEL1	\$67.88	\$66.55	Day
AL2	Assist Living Waiver/Diem	T2031	U7	U2		U7=WAIVER U2=LEVEL2	\$74.80	\$73.33	Day
AL3	Assist Living Waiver/Diem	T2031	U7	U3		U7=WAIVER U3=LEVEL3	\$82.55	\$80.93	Day
ATTC	Attendant Care Services (Agency)	S5125	U7	UA		U7=WAIVER UA=PROVIDER (AGENCY)	\$4.79	\$3.99	.25 Hour
ATTC	Attendant Care Services (Consumer Directed)	S5125	U7	U1		U7=WAIVER U1=ATTC FI	\$2.75	N/A	.25 Hour
ATTC	Attendant Care Services (Nonagency)	S5125	U7			U7=WAIVER	\$2.91	\$2.44	.25 Hour
BMN1	Behavioral Health Counsel	H0004	U7	U1		U7=WAIVER U1=LEVEL 1	N/A	\$17.38	.25 Hour
BMAN	Behavioral Health Counsel	H0004	U7	U2		U7=WAIVER U2=LEVEL 2	N/A	\$17.38	.25 Hour
CMFR	Case Management	T2022	U7			U7=WAIVER	\$100.00	\$100.00	Monthly Rate
HCC1	Case Management, Per Mnth (Health Care Coordination)	T2022	U7	U3		U7=WAIVER U3=LEVEL3	N/A	\$144.18	Monthly Rate
HCC1	Case Management, Per Mnth (Health Care Coordination)	T2022	U7	U4		U7=WAIVER U4=LEVEL4	N/A	\$192.24	Monthly Rate
HCC1	Case Management, Per Mnth (Health Care Coordination)	T2022	U7	U1		U7=WAIVER U1=LEVEL1 Health Care Coordination	N/A	\$48.06	Monthly Rate
HCC1	Case Management, Per Mnth (Health Care Coordination)	T2022	U7	U2		U7=WAIVER U2=LEVEL2 Health Care Coordination	N/A	\$96.12	Monthly Rate

INsite Code	Service	Price Code	Mod 1	Mod 2	Mod 3	Dsc Proc Modified	A&D 127	TB 131	Notes
HCC1	Case Management, Per Mnth (Health Care Coordination)	T2022	U7	U1		U7=WAIVER Health Care Coordination	\$ 9.74	N/A	.25 Hour rate, max 8 Hrs – New for SFY2009
CT	Comm Trans Waiver/Service	T2038	U7			U7=WAIVER	\$1,500.00	\$1,500.00	Lifetime Cap
AS14	Day Care Services, Adult	S5100	U7	U1		U7=WAIVER U1=LEVEL1	N/A	\$1.38	.25 Hour
AS24	Day Care Services, Adult	S5100	U7	U2		U7=WAIVER U2=LEVEL2	N/A	\$1.80	.25 Hour
AS34	Day Care Services, Adult	S5100	U7	U3		U7=WAIVER U3=LEVEL3	N/A	\$2.14	.25 Hour
ADS1	Day Care Services, Adult	S5101	U7	U1		U7=WAIVER U1=LEVEL1	N/A	\$21.95	1/2 Day Unit
ADS2	Day Care Services, Adult	S5101	U7	U2		U7=WAIVER U2=LEVEL2	N/A	\$28.80	1/2 Day Unit
ADS3	Day Care Services, Adult	S5101	U7	U3		U7=WAIVER U3=LEVEL3	N/A	\$34.29	1/2 Day Unit
AD1	Day Care Services, Adult	S5100	U7	U1		U7=WAIVER U1=LEVEL1	\$3.06	N/A	.25 Hour
AD2	Day Care Services, Adult	S5100	U7	U2		U7=WAIVER U2=LEVEL2	\$3.06	N/A	.25 Hour
AD3	Day Care Services, Adult	S5100	U7	U3		U7=WAIVER U3=LEVEL3	\$3.06	N/A	.25 Hour
PRSI	Emergency Response	S5160	U7			U7=WAIVER	\$54.41	\$52.07	Install
PRSM	Emergency Response	S5161	U7			U7=WAIVER	\$54.41	\$52.07	Monthly Rate
AF1	Family Care, Adult;	S5141	U7	U1		U7=WAIVER U1=LEVEL1	\$58.63	\$57.48	Day
AF2	Family Care, Adult	S5141	U7	U2		U7=WAIVER U2=LEVEL2	\$69.29	\$67.93	Day
AF3	Family Care, Adult	S5141	U7	U3		U7=WAIVER U3=LEVEL3	\$79.95	\$78.38	Day
HDM	Home Delivered Meals, Inc	S5170	U7			U7=WAIVER	\$5.43	\$5.32	Per Meal
SPEC EXAM	Home Modification Assessment – Spec	T1028	U7			U7=WAIVER	\$500.00	N/A	Annual Cap \$300.00 Spec \$200.00 Exam
HOMI	Home Modification Install	S5165	U7	NU		U7=WAIVER NU=NEW DME	\$15,000.00	\$15,000.00	Life Cap
HOMM	Home Modification Maintenance	S5165	U7	U8		U7=WAIVER U8=REPLACE MENT AND REPAIR	\$500.00	\$500.00	Annual Cap
HMK	Homemaker Service, NOS	S5130	U7	UA		U7=WAIVER UA=PROVIDE R	\$3.78	\$3.15	.25 Hour
HMK	Homemaker Service, NOS (Nonagency)	S5130	U7			U7=WAIVER	\$2.75	\$2.29	.25 Hour
NUTS	Nutritional Supplement	B4150	U7			U7=WAIVER (Annual Cap)	\$1,200.00	\$1,200.00	Annual Cap
RBHA	Residential Based Habilitation	97535	U7			U7=WAIVER	N/A	\$6.99	.25 Hour
RNUR	Respite Care Services	T1005	U7	UA	TD	U7=WAIVER UA=PROVIDE R; TD=RN	\$9.93	\$7.79	.25 Hour

INsite Code	Service	Price Code	Mod 1	Mod 2	Mod 3	Dsc Proc Modified	A&D 127	TB 131	Notes
RNUR	Respite Care Services	T1005	U7	UA	TE	U7=WAIVER UA=PROVIDER, TE=LPN	\$6.83	\$5.91	.25 Hour
ATCH	Specialized Medical Equip	T2029	U7	NU		U7=WAIVER NU=NEW DME	\$50,000.00	\$50,000.00	No Cap, \$50k is Manual Review
ATCM	Specialized Medical Equip	T2029	U7	U8		U7=WAIVER U8=REPLACEMENT AND REPAIR	\$500.00	\$500.00	Annual Cap
HDG	Structured Day Program-Group	T2021	U7	HQ		U7=WAIVER HQ=GROUP SETTING	N/A	\$1.67	.25 Hour
HDI	Structured Day Program-Individual	T2021	U7			U7=WAIVER	N/A	\$8.38	.25 Hour
SFC1	Structured Family Care, Level 1	S5140	U7	U1		U7=WAIVER U1= LEVEL 1	\$58.63	N/A	Day
SFC2	Structured Family Care, Level 2	S5140	U7	U2		U7=WAIVER U2=LEVEL 2	\$69.20	N/A	Day
SFC3	Structured Family Care, Level 3	S5140	U7	U3		U7=WAIVER U3= LEVEL 3	\$79.94	N/A	Day
HSE	Supported Employ	H2023	U7			U7=WAIVER	N/A	\$9.17	.25 Hour
RHHA	Unskilled Respite Care, N	S5150	U7	UA	U9	U7=WAIVER UA=PROVIDER; U9=HOME HEALTH AIDE	\$5.12	\$4.00	.25 Hour
VMOD	Vehicle Modifications	T2039	U7			U7=WAIVER	\$15,000.00	\$15,000.00	Life Cap
VMOM	Vehicle Modifications-Maintenance	T2039	U7	U8		U7=WAIVER U8=Maintenance	\$500.00	\$500.00	Annual Cap
PEST	Waiver Service, Nos	T2025	U7	U1		U7=WAIVER U1=PEST CONTROL	\$600.00	\$600.00	Annual Cap

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Section 3: Quality Assurance /Quality Improvement

Quality Monitoring

The Division of Aging (DA) is responsible for monitoring compliance with the provider and case management standards for the waivers administered by DA as detailed in 455 IAC. Noncompliance with the standards may result in corrective action plans or other sanctions, up to and including termination as a waiver provider.

The purpose of the Division of Aging Quality Assurance (QA) and Quality Improvement (QI) Unit is to protect the safety and well-being of individuals by monitoring and ensuring the integrity and cost-effectiveness of programs administered by the Division of Aging. The role of the DA QA/QI Unit is to:

- Monitor all providers who are not licensed by the Indiana State Department of Health (ISDH).
- Assure services to all participants are delivered in accordance with the participant's service plan, the specifications identified in the approved waiver and 455 IAC.
- Collect and analyze information and data in order to implement sound remediation of problems at the individual, organization, and systemic levels.
- Participate with other stakeholders in the development of policies and procedures that all providers, including case managers, must follow to assure compliance with Indiana Administrative Codes (IAC) and Centers for Medicare and Medicaid Services (CMS) assurances, and to protect participants' health and welfare.

The components of the DA QA/QI program are:

- Incident reporting
- Complaint resolution
- Mortality review
- Coordination with Adult Protective Services (APS) and the local Area Agencies on Aging (AAAs) and case managers
- Quality reviews (provider compliance surveys, participant-centered compliance surveys, participant experience surveys)
- Coordination with Medicaid Surveillance and Utilization Review (SUR) and the ISDH
- Implementation of the Quality Improvement Strategy (QIS) process

Incident Reporting

Providers with first knowledge of a reportable event are required to report that event via the designated website at <https://ddrsprovider.fssa.in.gov/IFUR>. To report incidents involving consumers of non-waiver Division of Aging services, please use <https://myweb.in.gov/FSSA/aging/incident/incident.aspx>.

Incidents are defined as unusual occurrences affecting the health and safety of Home and Community-Based Services (HCBS) waiver participants, including death. Incidents are required to be reported within 48 hours of knowledge of the event, or within 24 hours of knowledge if the incident involves suspicion or evidence of abuse, neglect, exploitation, or death. Providers are required to send copies of all incident reports to the participant's case manager. Incidents involving suspicion or evidence of abuse, neglect, exploitation, or death must also be reported to APS or Child Protective Services (CPS),

as applicable. Each provider of services must establish and make available to the participant a written procedure for reporting incidents to DA.

Reportable incidents include, but are not limited to:

- Alleged, suspected, reported, or observed abuse or battery, neglect, or exploitation of a participant. The provider is required to suspend staff alleged to have committed abuse, neglect, or exploitation from direct-care responsibilities, pending the outcome of the provider's investigation.
- The death of a participant
- Significant injury to the participant
- Any suicidal ideation, threat, or attempt of suicide made by the participant
- A missing person (participant)
- Inadequate formal or informal support for a participant, including inadequate supervision, which endangers the participant
- Medication error occurring in a 24/7 or day-program setting
- A residence that compromises the health and safety of a participant, including pest infestations that represent a potential source of harm
- Suspected or observed criminal activity by staff, a family caregiver, or a participant receiving services.
- Police arrest of the participant or any person responsible for the care of the participant
- A major disturbance or threat to public safety created by the participant
- Any use of restraint on the participant, including but not limited to, physical, mechanical, and pharmaceutical

Providers are required to report incidents regardless of whether they were providing services at the time of the incident. All provider staff should be familiar with incident reporting (IR) requirements and procedures because knowledge of an incident begins as soon as any employee of the provider becomes aware of the event. If a provider or case manager has confirmed with another provider that an incident has already been reported, an additional report is not required, but the provider may wish to file an additional report to relay additional information or another perspective of the event.

The DA reviews, codes, and determines the level of follow-up required for an incident. Additional information may be requested from the provider or case manager. When formal follow-up is required, the case manager is required to submit follow-up reports via the web-based incident reporting system every seven days until the DA closes the report.

Complaint Resolution

The DA addresses complaints submitted by or on behalf of any individual receiving services through a waiver administered by the DA. Complaints may be initiated by any individual through the IR system, mail, telephone, or fax. Complaint investigations may result in findings requiring remediation. A provider's failure to complete remediation may result in sanctions up to and including termination as a waiver provider.

Mortality Review

As part of its QA/QI process, the DA reviews all waiver consumer deaths to identify service delivery failures or opportunities for improvement at the provider and system level. Providers may be asked to submit case notes, service delivery records, or other pertinent information or records for review. The Mortality Review Committee (MRC) may refer waiver providers, case managers, or non-waiver

service providers to the relevant regulatory body, including law enforcement, for additional action. The MRC may also refer complaints against a waiver provider or case manager for internal remediation through the complaint resolution process.

Quality Reviews

The DA conducts Provider Compliance Reviews (PCRs) for all non-licensed waiver service providers, and licensed providers when they also offer services which fall outside of the scope of the license. The PCR includes a review of provider policies and adherence to State and federal requirements as well as the provider's own policies. Providers are reviewed at least every three years.

The State has contracted with a quality assurance organization to administer Person Centered Compliance Reviews and Participant Experience Surveys. Person Centered Compliance Reviews will entail a participant interview, an extensive review of provider and case manager documentation, service delivery records, policies and procedures, and compliance with other waiver and State requirements.

Findings of one or more deficiencies relating to provider standards will result in a remediation process to correct the deficiencies. Provider failure to cooperate with the review procedure or to complete the remediation process will result in a referral to the DA QA/QI Unit as a formal complaint, which may result in sanctions up to and including termination as a waiver provider.

QIS Process

The Division of Aging QA/QI Unit aggregates and analyzes data from all waiver processes to identify incidents of noncompliance with waiver requirements and opportunities to achieve more positive outcomes. Findings are reviewed for viable remediation options at the individual and systemic levels. Provider failure to complete required remediation may result in sanctions up to and including termination as a waiver provider.

The QA/QI Unit, working in conjunction with the OMPP and the QA/QI Committee, recommends systemic improvements and assesses the performance of the QA/QI components.

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Section 4: Financial Oversight

Waiver Audits

The state of Indiana employs a hybrid program integrity (PI) approach to oversight of the waiver programs, incorporating oversight and coordination by a dedicated waiver specialist position within the Surveillance and Utilization Review (SUR) Unit, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) contractor arrangements. The Family and Social Services Administration (FSSA) has expanded its PI activities using a multifaceted approach to SUR activity that includes provider self-audits, desk audits, and on-site audits. The FADS team analyzes claims data, allowing them to identify providers and claims that indicate aberrant billing patterns or other risk factors.

The PI audit process uses data mining, research, identification of outliers, problematic billing patterns, aberrant providers, and issues that are referred by other divisions and State agencies. In 2011, the State of Indiana formed a Benefit Integrity Team comprised of key stakeholders that meets biweekly to review and approve audit plans, provider communications and make policy and system recommendations to affected program areas. The SUR Unit also meets with all waiver divisions on a quarterly basis, at a minimum, and receives referrals on an ongoing basis to maintain open lines of communication and aid in understanding specific areas of concern such as policy clarification.

The SUR waiver specialist is a subject-matter expert (SME) responsible for directly coordinating with the various waiver divisions. This specialist also analyzes data to identify potential areas of program risk and identify providers that appear to be outliers warranting review. The SME may also perform desk or on-site audits and be directly involved in review of waiver providers and programs.

The FSSA maintains oversight throughout the entire PI process. Although the FADS contractor may be incorporated in the audit process, no audit is performed without the authorization of the FSSA. The FSSA's oversight of the contractor's aggregate data is used to identify common problems to be audited, determine benchmarks, and offer data to peer providers for educational purposes, when appropriate.

The SUR Unit offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with federal and State guidelines, including all Indiana Health Coverage Programs (IHCP) and waiver requirements. Detailed information on SUR policy and procedures is available in [Chapter 13](#) of the *IHCP Provider Manual*.

FSSA Audit Oversight

The Audit Division of the FSSA reviews waiver audit team schedules and findings to reduce redundancy and assure use of consistent methodology.

Medicaid Fraud Control Audit Overview

The Indiana Medicaid Fraud Control Unit (MFCU) is an investigative branch of the Attorney General's Office. MFCU conducts investigations in the following areas:

- Medicaid provider fraud
- Misuse of Medicaid members' funds

- Patient abuse or neglect in Medicaid facilities

When the MFCU identifies a provider that has violated one of these areas, the provider's case is presented to the State or federal prosecutors for appropriate action. Access information about the [MFCU](http://mfcu.in.gov/attorneygeneral) at mfcu.in.gov/attorneygeneral.

Section 5: Division of Aging Waivers

Overview

Indiana administers two home and community-based waivers for persons who meet eligibility for nursing facility services:

- Waiver for persons who are aged or disabled
- Waiver for persons with a traumatic brain injury

Per agreement with the State Medicaid agency the Division of Aging (DA) has responsibility for the day-to-day operations of these waivers according to the approved waiver documents. The State Medicaid agency retains oversight authority.

Level of Care (LOC)

Persons who meet eligibility for the Aged & Disabled (A&D) Waiver must meet nursing facility (NF) level of care. The criteria necessary to meet this level of care is outlined in *405 IAC 1-3*. View the most up-to-date version of *405 IAC 1-3* in its entirety at in.gov/legislative/iac. Persons who meet eligibility for the Traumatic Brain Injury waiver must meet nursing facility level of care (LOC) or intermediate care facility for individuals with intellectual disabilities (ICF/IID) LOC.

Aged & Disabled Waiver

The Aged & Disabled waiver is designed to provide an alternative to nursing facility admission for Medicaid-eligible persons age 65 and older, and persons of all ages with disabilities by providing supports to complement and supplement informal supports for persons who would require care in a nursing facility if waiver services or other supports were not available. Indiana's 16 Area Agencies on Aging act as the entry points for this waiver. The services available through this waiver are designed to help participants remain in their own homes, as well as to assist individuals residing in nursing facilities to return to community settings, such as their own homes, apartments, assisted living, or adult family care.

- Participant eligibility
 - Individuals meeting nursing facility LOC and Medicaid eligibility requirements must meet at least one of the following criteria to receive services through this waiver:
 - Age 65 and older
 - Disabled
 - Entry to the waiver may be delayed due to the existence of a waiting list.
 - Priority admittance to the waiver may be made based on criteria outlined in the approved waiver.
- Medicaid aid (MA) categories
 - Aged (MAA)
 - Blind (MAB)
 - Disabled (MAD)
 - Working disabled (MADW and MADI)
 - 42 CFR 435.110 Parents and other caretaker relatives (MA GF)

- 42 CFR 435.118 Infants and children under age 19 (MA Y; MA Z; MA 2; MA 9)
- 42 CFR 435.145 Children for whom adoption assistance or foster care maintenance payments are made (under title IV-E of the Act) (MA 4; MA 8)
- 42 CFR 435.150 Former Foster Care Children; Sec. 1902(a)(10)(A)(i)(IX) (MA 15)
- 42 CFR 435.226 Independent Foster Care Adolescents; Sec. 1902(a)(10)(A)(ii)(VII) (MA 14)
- 42 CFR 435.227 Individuals under age 21 who are under State adoption assistance agreements (MA 8)
- Sec 1925 of the Act –Transitional Medical Assistance (MA F)
- Services available (see [Section 7](#) for service definitions):
 - Adult day services
 - Adult family care
 - Assisted living
 - Attendant care
 - Case management
 - Community transition
 - Environmental modification
 - Environmental modification assessment
 - Healthcare coordination
 - Home-delivered meals
 - Homemaker
 - Nutritional supplements
 - Personal emergency response system
 - Pest control
 - Respite care
 - Structured family caregiving
 - Specialized medical equipment and supplies
 - Transportation
 - Vehicle modification

Traumatic Brain Injury Waiver (TBI)

The Traumatic Brain Injury waiver provides home and community-based services to individuals who, but for the provision of such services, would require institutional care.

Indiana defines a traumatic brain injury as a trauma that has occurred as a closed- or open-head injury by an external event that results in damage to brain tissue, with or without injury to other body organs. Examples of external agents are mechanical or events that result in interference with vital functions. Traumatic brain injury means a sudden insult or damage to brain function, not of a degenerative or congenital nature. The insult or damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional, or physical functioning resulting in partial or total disability not including birth trauma related injury.

- Participant eligibility
 - Waiver participants must meet the minimal LOC requirements for that of a NF or intermediate care facility for individuals with intellectual disabilities (ICF/IID) and have a diagnosis of traumatic brain injury.
 - Entry to the waiver may be delayed due to the existence of a waiting list.

- Priority admittance to the waiver may be made based on criteria outlined in the approved waiver.
- Medicaid aid (MA) categories
 - Aged (MAA)
 - Blind (MAB)
 - Disabled (MAD)
 - Working disabled (MADW and MADI)
 - 42 CFR 435.110 Parents and other caretaker relatives (MA GF)
 - 42 CFR 435.118 Infants and children under age 19 (MA Y; MA Z; MA 2; MA 9)
 - 42 CFR 435.145 Children for whom adoption assistance or foster care maintenance payments are made (under title IV-E of the Act) (MA 4; MA 8)
 - 42 CFR 435.150 Former Foster Care Children; Sec. 1902(a)(10)(A)(i)(IX) (MA 15)
 - 42 CFR 435.226 Independent Foster Care Adolescents; Sec. 1902(a)(10)(A)(ii)(VII) (MA 14)
 - 42 CFR 435.227 Individuals under age 21 who are under State adoption assistance agreements (MA 8)
 - Sec 1925 of the Act – Transitional Medical Assistance (MA F)
 -
- Services available (see to [Section 7](#) for service definitions):
 - Adult day services
 - Adult family care
 - Assisted living
 - Attendant care
 - Behavior management/behavior program and counseling
 - Case management
 - Community transition
 - Environmental modification
 - Healthcare coordination
 - Home-delivered meals
 - Homemaker
 - Nutritional supplements.
 - Personal emergency response system
 - Pest control
 - Residential-based habilitation
 - Respite
 - Specialized medical equipment and supplies
 - Structured-day program
 - Supported employment
 - Transportation
 - Vehicle modification

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Section 6: Case Management

For Aged & Disabled and Traumatic Brain Injury Waivers

Medicaid waiver case managers coordinate and integrate all services required in a participant's person centered service plan, link participants to needed services, and ensure that participants continue to receive and benefit from services. Waiver case managers enable participants to receive a full range of services needed due to a medical condition, in a planned, coordinated, efficient, effective manner.

Case management is a comprehensive service comprised of specific tasks and activities designed to coordinate and integrate all other services required in the participant's service plan.

The components of case management are:

- Initial level of care (LOC) assessment
- Development of service plans including coordination of formal and informal supports
- Implementation of the service plan
- Assessment and care planning for discharge from institutionalization
- Bi-annual and ongoing reassessments of LOC
- Quarterly assessment of individual's needs, per 90-Day Review tool
- Periodic updates of service plans
- Monitoring the quality of home care community services
- Determining and monitoring the cost effectiveness of providing home and community-based services
- Information and assistance services
- Enhancement or termination of services based on need
- Administrative guidance
- Participation in Medicaid Fair Hearing process

Case management services for persons on the nursing facility Medicaid waivers are provided by certified case managers, as approved by the Division of Aging (DA). The 16 local Area Agencies on Aging (AAA) serve as the single point of entry for the nursing facility Medicaid waivers. A case manager from the AAA is assigned to an applicant. After an applicant has been determined to meet the eligibility criteria and approved to receive nursing facility Medicaid waiver services, he or she may choose to retain his or her current AAA case manager or choose a non-AAA or independent case manager, for ongoing case management services.

Minimum qualifications for case managers are the following:

- All case management services provided must comply with the case management standards.
- The minimum educational and experience criteria for providing this service under the A&D and TBI waivers are:
 - A Qualified Mental Retardation Professional (QMRP) who meets the QMRP requirements at 42 CFR 483.430
 - A registered nurse with one year's experience in human services; or
 - A bachelor's degree in social work, psychology, sociology, counseling, gerontology, or nursing; or health and human services; or

- A bachelor's degree in any field with a minimum of two years' full-time direct-service experience with the elderly or disabled (including assessment, care plan development, and monitoring); or
- A master's degree in a related field may substitute for the required experience
- An individual continuously employed as a case manager by an Area Agency on Aging (AAA) since January 1, 1990 (A&D waiver only)
- All case managers must complete the Division of Aging Case Management Orientation Online (CMO) Training Modules before providing waiver case management services. Until a case manager has successfully completed the orientation, he or she may not work independently.
- All case managers must annually obtain at least 20 hours of training regarding case management services. Ten hours of this training must be training approved by the DA under the nursing facility waiver program.

If the DA identifies a systemic problem with a case manager's services, the case manager must obtain training on the topics recommended by the DA.

Case management may not be conducted by any organization, entity, or individual that also delivers other in-home and community-based services under the DA waiver programs, or any organization, entity, or individual related by common ownership or control to any other organization, entity, or individual that also delivers other in-home and community-based services under the nursing facility waiver program. The exception is an AAA that has been granted permission by the Family and Social Services Administration (FSSA) to provide direct services to clients.

- *Common Ownership* exists when an individual, individuals, or any legal entity possesses ownership or equity of at least 5% in the provider entity, as well as the institution or organization serving the provider. *Control* exists where an individual or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not the control is actually exercised.
- *Related* means associated or affiliated with, or having the ability to control, or be controlled by.

Reimbursement of case management services, as defined in this manual, may not be made unless and until the client becomes eligible for waiver service. Case management service provided to individuals who are not eligible for DA waiver services will not be reimbursed as a waiver service.

Case Management Monitoring Standards

The *Ongoing Medicaid Home and Community-Based Services Waiver Case Management Standards* is the document that delineates the standards each nursing facility waiver case manager must meet to fulfill the FSSA DA guiding principles of:

- Responsive, efficient, effective, quality, and timely service delivery
- Effective communication
- Respect, dignity, integrity, and rights for all individuals
- Person-centered planning, informed choice, and personal empowerment
- Community-based services
- Fiscal stewardship
- Quality customer services

Case managers are to comply with all applicable DA standards. The following section is excerpted from the *Case Management Medicaid Waiver Provider Agreement*.

Ongoing Medicaid Home and Community-Based Services Waiver Case Management Standards

1. Case managers will maintain the highest professional and ethical standards in the conduct of their business.
2. Case managers will comply with all DA-issued manuals, as well as all federal, state, and local law, and all FSSA policy, rules, regulations and guidelines, including the *Health Insurance Portability and Accountability Act* (HIPAA).
3. New case managers will complete case manager orientation as approved by the DA prior to being eligible for Medicaid reimbursement. This orientation is now provided online and can be accessed at www.in.gov/fssa/da/3491.htm. Completion of the modules is verified through completion of the final certification test. Division of Aging grades the test and issues certification for any score of 80% or higher.
4. Case managers are required to complete annual training as follows:
 - 1) The following components of the online orientation must be reviewed annually by all active case managers:
 - a) Level of care modules – general, narrative, skilled needs, and activities of daily living
 - b) Incident reporting module
 - c) Service definition module
 - 2) An additional eighteen (18) hours of training must be completed annually by all active case managers.
 - a) This training does not have to be preapproved by the Division of Aging.
 - b) This training does have to be relevant to core case management functions.
 - c) The Training Justification Form must be completed.
 - d) Training documentation is subject to review in compliance surveys and at Division of Aging request.
 - e) Relevant topics can include the following:
 - i) Care coordination
 - ii) Documentation
 - iii) Medical terminology
 - iv) Other public or privately funded long-term services and support programs or benefits
 - v) Specific diagnosis or treatment topics affecting a broad spectrum of the client base, including but not limited to:
 - (1) Fall prevention
 - (2) Adaptive equipment
 - (3) COPD
 - (4) Congestive heart failure
 - (5) Diabetes
 - (6) Traumatic brain injury
 - (7) Kidney disease
 - (8) Alzheimer's Disease
 - (9) Seizures
 - (10) Stroke
 - (11) Heart disease
 - (12) Mental health issues
 - (13) Behavioral issues
 - 3) The following will NOT be accepted as part of the required training:
 - a) Case management orientation
 - b) Required annual re-trainings as cited in 4)
 - c) Vendor fairs
 - d) Staff meetings (unless there is an outside speaker or expert speaking on a relevant topic or someone who attended a State training as a trainer is sharing that information)

- e) Presentations related to employment issues, e.g. performance appraisal process, retirement; and;
 - f) Communications that are part of supervisory oversight, e.g. reinforcement or retraining on job requirements, review of state guidelines, informational, or training, sessions specific to a case, etc.
- 4) Required training hours are prorated in a case manager's first year and are in addition to new case manager orientation.
 5. Individuals will choose their service provider, including their case manager, and have the right to change any provider, including their case manager.
 6. Case managers will provide individuals a list of potential providers, furnished by the state of Indiana, including case managers and the services offered by each provider.
 7. Case managers will provide, at a minimum but not limited to, a state information guide to individuals on how to choose a provider and will assist the individual to evaluate potential service providers.
 8. A maximum response time between implementation of the initial service plan and the first monitoring contact will be no more than 30 calendar days.
 9. Case managers will have face-to-face contact with each individual a minimum of every 90 days to assess the quality and effectiveness of the service plan. At least two of these face-to-face contacts per year will be in the home setting.
 10. Case managers will document, in the chronological narrative, each contact with the individual and each contact with providers within seven days of activity.
 11. Case manager documentation **must** show activity relevant to the service plan to be reimbursed.
 12. Case managers will facilitate and monitor the formal and informal supports that are developed to maintain the individual's health and welfare in the community.
 13. Case managers will provide each individual or guardian with clear and easy instructions for contacting the case manager or case manager agency. The case manager will also provide additional information and procedures for individuals who may need assistance or have an emergency that occurs before or after business hours. This information will be located in the home in a location that is visible from the telephone.
 14. Case managers will complete face-to-face Annual Assessments and update the service plan as needed, in collaboration with the individual, in a timely and appropriate manner to avoid gaps in service authorization, including assuring that the individual or guardian receives instructions on how to request an appeal through the Medicaid Fair Hearing process.
 15. Case managers will communicate the individual's needs, strengths, and preferences to the support team.
 16. Case managers will ensure that person centered planning is occurring on an ongoing basis.
 17. Case managers will monitor the ongoing services to ensure that they reflect the service plan, including the individual's medication regime.
 18. Case managers will base the service plan upon the individual's needs, strengths, and preferences.
 19. Case managers will ensure that the individual and all providers have a current, comprehensive service plan that meets the needs of the individual.
 20. Case managers will review and explain to the individual or guardian the services that will be provided, and the individual or their designated representative will sign the service plan to show understanding of, and agreement with, the plan.

21. Case managers will ensure that the individual or guardian, providers, and involved agencies have a copy of relevant documentation, as specified in the *Waiver Case Management Manual*, including instructions on how to request an appeal.
22. Case managers will obtain all required signatures on the service plan before submitting it to the State. The service plan will not be implemented prior to receiving State approval.
23. Case managers will document the quality; timeliness; and appropriateness of care, services, and products delivered by providers.
24. Case managers will initiate timely follow-up of identified problems, whether self-identified or referred by others. Critical or crisis issues, including incident reports, will be acted upon immediately, as specified by the DA. All follow-up and resolution will be documented in the individual record.
25. Case managers will comply with all automation standards and requirements as prescribed by the DA for documentation and processing of case management activities.
26. Case managers will maintain privacy and confidentiality of all individual records. No information will be released or shared with others without the individual or guardian's written consent.
27. Case managers will provide to the State upon request, ready access to all case manager documentation, either electronic or hard copy.
28. Case manager documentation will demonstrate that the safety and welfare of the individual are being monitored on a regular basis.

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Section 7: Service Definitions

Service Definition Overview

This section of the manual lists service definitions for the services currently approved for the Home and Community-Based Services (HCBS) Nursing Facility Level of Care waiver program. Each service definition includes the following information as appropriate:

- Service definition
- Allowable activities
- Service standards
- Documentation standards
- Limitations
- Activities not allowed
- Provider qualifications
 - A provider qualifications table identifies the waiver, the license or certification requirements, and any additional standards that apply.

[Table 2.1](#) shows procedure (billing) codes and modifiers, as well as unit rates.

Adult Day Services

Service Definition

Adult day services (ADS) are community-based group programs designed to meet the needs of adults with impairments through individual service plans. These structured, comprehensive, nonresidential programs provide health, social, recreational, and therapeutic activities, supervision, support services, and personal care. Meals or nutritious snacks are required. The meals cannot constitute the full daily nutritional regimen. However, each meal must meet one-third of the daily Recommended Dietary Allowance. These services must be provided in a congregate, protective setting.

Participants attend ADS on a planned basis. The three levels of ADS are basic, enhanced, and intensive. The ADS Assessment Tool may be obtained from the [Division of Aging](#) website. The assessment should be conducted with the individual being served, his or her family, the case manager, and the provider, when possible.

Allowable Activities

Basic adult day services (Level 1) include:

- Monitoring or supervising all activities of daily living (ADLs) – defined as dressing, bathing, grooming, eating, walking, and toileting – with hands-on assistance provided as needed
- Comprehensive, therapeutic activities
- Health assessment and intermittent monitoring of health status
- Monitoring medication or medication administration
- Appropriate structure and supervision for those with mild cognitive impairment
- Minimum staff ratio of one staff for each eight individuals
- Registered nurse (RN) consultant available

Section 7: Service Definitions

Enhanced adult day services (Level 2) include all Level 1 service requirements. Additional Level 2 services include:

- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care
- Health assessment with regular monitoring or intervention with health status
- Dispensing or supervising the dispensing of medication to individuals
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers
- Therapeutic structure, supervision, and intervention for those with mild to moderate cognitive impairments
- Minimum staff ratio of one staff for each six individuals
- RN consultant available
- Minimum of one full-time licensed practical nurse (LPN) with monthly RN supervision

Intensive adult day services (Level 3) include all Level 1 and Level 2 service requirements. Additional Level 3 services include:

- Hands-on assistance or supervision with all ADLs and personal care
- One or more direct health interventions required
- Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy coordinated or available
- Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care
- Therapeutic interventions for those with moderate to severe cognitive impairments
- Minimum staff ratio of one staff for each four individuals
- RN consultant available
- Minimum of one full-time LPN with monthly RN supervision
- Minimum of one qualified full-time staff person to deal with participants' psycho-social needs

Service Standards

Adult day services must follow a written service plan addressing specific needs determined by the client's assessment

Documentation Standards

- Identified need in the service plan
- Services outlined in the service plan
- Evidence that the level of service provided is required by the individual
- Attendance record documenting the date of service and the number of units of service delivered that day
- Completed *Adult Day Service Level of Service Evaluation* form. The case manager must give the completed *Adult Day Service Level of Service Evaluation* form to the provider.

Limitations

Adult day services are allowed for a maximum of 10 hours per day.

Activities Not Allowed

Any activity that is not described in allowable activities is not included in this service. Services to participants receiving assisted living waiver service are not allowed.

Note: Therapies provided through this service will not duplicate therapies provided under any other service.

Provider Qualifications

Table 7.1 – Provider Qualifications Table for Adult Day Service

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	FSSA/DA approved Adult Day Service Provider	Not required	DA approved 455 IAC 2 Provider Qualifications: Becoming an approved provider; maintaining approval 455 IAC 2 Provider Qualifications: General requirements 455 IAC 2 Provider Qualifications: General requirements for direct care staff 455 IAC 2 Procedures for Protecting Individuals 455 IAC 2 Unusual occurrence; reporting 455 IAC 2 Transfer of individual's record upon change of provider 455 IAC 2 Notice of termination of services 455 IAC 2 Provider organizational chart 455 IAC 2 Collaboration and quality control 455 IAC 2 Data collection and reporting standards 455 IAC 2 Quality assurance and quality improvement system 455 IAC 2 Financial information 455 IAC 2 Liability insurance 455 IAC 2 Maintenance of personnel records 455 IAC 2 Adoption of personnel policies 455 IAC 2 Operations manual 455 IAC 2 Maintenance of records of services provided 455 IAC 2 Individual's personal file; site of service delivery 455 IAC 2 Maintenance of records of services provided 455 IAC 2 Individual's personal file; site of service delivery

Adult Family Care

Service Definition

Adult family care (AFC) is a comprehensive service in which a participant resides with an unrelated caregiver for the participant to receive personal assistance designed to provide options for alternative long-term care to individuals who meet nursing facility level of care and whose needs can be met in a home-like environment. The participant and up to three other participants who are elderly or have physical or cognitive disabilities who are not members of the provider's or primary caregiver's family, reside in a home that is owned, rented, or managed by the AFC provider.

The goal of the service is to provide necessary care while emphasizing the participant's independence. This goal is reached through a cooperative relationship between the participant (or the participant's legal guardian), the participant's HCBS Medicaid waiver case manager, and the AFC provider. Participant needs shall be addressed in a manner that supports and enables the individual to maximize abilities to function at the highest possible level of independence. The service is designed to provide options for alternative long-term care to persons who meet nursing facility level of care, and whose needs can be met in an AFC setting.

Another goal is to preserve the dignity, self-respect, and privacy of the participant by ensuring high-quality care in a non-institutional setting. Care is to be furnished in a way that fosters the independence of each participant to facilitate aging in place in a home environment that will provide the participant with a range of care options as the needs of the participant change.

Participants selecting AFC service may also receive case management service, adult day service, specialized medical equipment and supplies, and healthcare coordination through the waiver.

Note: Participants living in AFC settings are entitled to retain at least their personal needs allowance (PNA) as established by the state of Indiana. The PNA is currently \$52.00 per month.

A provider, after ensuring that the participants retain their PNA, may bill participants up to the current maximum federal Supplemental Security Income (SSI). Providers may not charge Medicaid waiver participants a room and board rate that exceeds the maximum SSI rate. The maximum SSI amount for 2015 is \$733.00.

Allowable Activities

The following are included in the daily *per diem* for AFC:

- Attendant care
- Chores
- Companion services
- Homemaker services
- Medication oversight (to the extent permitted under State law)
- Personal care and services
- Transportation for community activities that are therapeutic in nature or assist with maintaining natural supports. (Medicaid State Plan transportation should be requested for medical transportation.)

- Consumer-focused activities that are appropriate to the needs, preferences, age, and condition of the individual participant
- Assistance with correspondence and bill paying, if requested by participant

Service Standards

- AFC services must follow a written service plan addressing specific needs determined by the individual's assessment.
- Services must address the participant's level of service needs.
- The provider must live in the AFC home, unless another provider-contracted primary caregiver, who meets all provider qualifications, lives in the provider's home.
- Backup services must be provided by a qualified individual familiar with the individual's needs for those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of care.
- AFC provides an environment that has the qualities of a home, including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences.
- Rules managing or organizing the home activities in the AFC home that are developed by the provider, a provider-contracted primary caregiver, or both, and approved by the Medicaid waiver program must be provided to the individual before the start of AFC services and may not be so restrictive as to interfere with a participant's rights under State and federal law.
- Consumer-focused activity plans are developed by the provider with the participant or the participant's representative.
- AFC emphasizes the participant's independence in a setting that protects and encourages the participant's dignity, choice, and decision-making while preserving self-respect.
- Providers or providers' employees who provide medication oversight, as addressed under *Allowable Activities*, must receive necessary instruction from a doctor, nurse, or pharmacist on the administration of controlled substances prescribed to the participant.

Documentation Standards

- Identified need in the service plan
- Services outlined in the service plan
- Completed *Adult Family Care Level of Service Evaluation* form required. (The case manager must give the completed *Adult Family Care Level of Service Evaluation* form to the provider.)
- Daily documentation to support services rendered by the AFC to address needs identified in the *Adult Family Care Level of Service Evaluation* form
 - Participant's status
 - Updates
 - Participation in consumer-focused activities
 - Medication management records, if applicable
- Maintenance of participant's personal records to include:
 - Social Security number
 - Medical insurance number
 - Birth date
 - All medical information available, including all prescription and nonprescription drug medication currently in use
 - Most recent prior residence
 - Hospital preference
 - Mortuary preference (if known)

Section 7: Service Definitions

- Religious affiliation and place of worship, if applicable
- Participant's personal records must contain copies of all applicable documents:
 - Advance directive
 - Living will
 - Power of attorney
 - Healthcare representative
 - Do-not-resuscitate (DNR) order
 - Letters of guardianship

Note: If applicable, copies must be:

- Placed in a prominent place in the consumer file
- Sent with the consumer when transferred for medical care

Activities Not Allowed

- Services provided in the home of a caregiver who is related by blood or related legally to the participant
- Adult family care services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the healthcare representative (HCR) of a participant, or the legal guardian of a participant
- Payments for room and board or the costs of facility maintenance, upkeep, or improvement
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional

The adult family care service *per diem* does not include room and board.

Separate payment will not be made for homemaker services, respite, environmental modifications, vehicle modifications, transportation, personal emergency response system, attendant care, assisted living, home-delivered meals, nutritional supplements, pest control, community transition, or structured family caregiving services furnished to a participant selecting adult family care services, as these activities are integral to and inherent in the provision of adult family care services.

Provider Qualifications

Table 7.2 – Provider Qualifications Table for Adult Family Care

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	FSSA/DA- approved Adult Family Care Individual	Not required	Provider and home must meet the requirements of the Indiana Adult Family Care Service Provision and Certification Standards. Adult family care service providers are required to maintain Commercial General Liability insurance with the Indiana Division of Aging identified as a Certificate Holder. DA approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider Qualifications; General requirements 455 IAC 2 General requirements for direct care staff 455 IAC 2 Procedures for protecting individuals 455 IAC 2 Unusual occurrence; reporting

Waiver	Provider	Licensure/ Certification	Other Standard
			455 IAC 2 Transfer of individual's record upon change of provider 455 IAC 2 Notice of termination of services 455 IAC 2 Provider organizational chart 455 IAC 2 Collaboration and quality control 455 IAC 2 Data collection and reporting standards 455 IAC 2 Quality assurance and quality improvement system 455 IAC 2 Financial information 455 IAC 2 Liability insurance 455 IAC 2 Transportation of an individual 455 IAC 2 Documentation of qualifications 455 IAC 2 Maintenance of personnel records 455 IAC 2 Adoption of personnel policies 455 IAC 2 Operations manual 455 IAC 2 Maintenance of records of services provided 455 IAC 2 Individual's personal file; site of service delivery
A&D, TBI	FSSA/DA approved Adult Family Care Agency	Not required	Provider and home must meet the requirements of the Indiana Adult Family Care Service Provision and Certification DA approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider Qualifications: General Requirements 455 IAC 2 General requirements for direct care staff 455 IAC 2 Procedures for protecting individuals 455 IAC 2 Unusual occurrence; reporting 455 IAC 2 Transfer of individual's record upon change of provider 455 IAC 2 Notice of termination of services 455 IAC 2 Provider organizational chart 455 IAC 2 Collaboration and quality control 455 IAC 2 Data collection and reporting standards 455 IAC 2 Quality assurance and quality improvement system 455 IAC 2 Financial information 455 IAC 2 Liability insurance 455 IAC 2 Transportation of an individual 455 IAC 2 Documentation of qualifications 455 IAC 2 Maintenance of personnel records 455 IAC 2 Adoption of personnel policies 455 IAC 2 Operations manual 455 IAC 2 Maintenance of records of services provided 455 IAC 2 Individual's personal file; site of service delivery

Assisted Living

Service Definition

Assisted living service is defined as personal care and services, homemaker services, chores, attendant care and companion services, medication oversight (to the extent permitted under State law), and therapeutic social and recreational programming provided in a home-like environment in a residential facility that is licensed by the Indiana State Department of Health (ISDH), in conjunction with residing in the facility. This service includes 24-hour, on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Other individuals or agencies may also furnish care directly or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Individuals reside in their own living units (which may include dually occupied units, when both occupants request the arrangement), which include kitchenette, toilet facilities, and a sleeping area (not necessarily designated as a separate bedroom from the living area). The individual has a right to privacy. Living units may be locked at the discretion of the individual, except when a physician or mental health professional has certified in writing that the individual is sufficiently impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity centers, which may also serve as living rooms or dining rooms. The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each individual to facilitate aging in place. Routines of care and service delivery must be individual-driven to the maximum extent possible and must treat each person with dignity and respect.

Participants selecting assisted living service may also receive case management service, specialized medical equipment and supplies, and community transition services through the waiver.

Note: Under 455 IAC 3-1-12, participants living in assisted living facilities are entitled to retain at least their personal needs allowance (PNA) as established by the state of Indiana. The PNA is currently \$52.00 per month.

A provider, after ensuring that the participants retain their PNA, may bill participants up to the current maximum federal Supplemental Security Income (SSI). Providers may not charge Medicaid waiver participants a room and board rate that exceeds the maximum SSI rate. The maximum SSI amount for 2015 is \$733.00.

Allowable Activities

The following are included in the daily *per diem* for assisted living services:

- Attendant care
- Chores
- Companion services
- Homemaker services

- Medication oversight (to the extent permitted under State law)
- Personal care and services
- Therapeutic social and recreational programming

Service Standards

Assisted living services must follow a written service plan addressing specific needs determined by the client's assessment.

Documentation Standards

- Services outlined in the service plan.
- Evidence that individual requires the level of service provided.
- Documentation to support service rendered.
- Negotiated risk agreement, if applicable.
- Completed *Assisted Living Level of Service Evaluation* form required. (The case manager must give the completed *Assisted Living Level of Service Evaluation* form to the provider.)

Activities Not Allowed

- The assisted living service *per diem* does not include room and board.
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional.

Separate payment will not be made for homemaker services, respite, environmental modifications, vehicle modifications, transportation, personal emergency response system, attendant care, adult family care, adult day services, home-delivered meals, nutritional supplements, pest control, or structured family caregiving furnished to a participant selecting assisted living services, as these activities are integral to and inherent in the provision of the assisted living service.

Provider Qualifications

Table 7.3 – Provider Qualifications Table for Assisted Living

Waiver	Provider	Licensure/ Certification	Other Standard
A&D	Licensed Assisted Living Agencies	IC 16-28-2	DA approved 410 IAC 16.2-5

Attendant Care

Service Definition

Attendant care services primarily involve hands-on assistance for aging adults and persons with disabilities. These services are provided to allow aging adults or persons with disabilities to remain in their own homes and to carry out functions of daily living, self-care, and mobility.

Allowable Activities

Homemaker activities that are essential to the individual's healthcare needs to prevent or postpone institutionalization, when provided during the provision of other attendant care services, are allowed:

- Provision of assistance with personal care, which includes:
 - Bathing, partial bathing
 - Oral hygiene
 - Hair care, including clipping of hair
 - Shaving
 - Hand and foot care
 - Intact skin care
 - Application of cosmetics
- Provision of assistance with mobility, which includes:
 - Proper body mechanics
 - Transfers
 - Ambulation
 - Use of assistive devices
- Provision of assistance with elimination, which includes:
 - Assistance with bedpan, bedside commode, and toilet
 - Incontinent or involuntary care
 - Emptying urine collection and colostomy bags
- Provision of assistance with nutrition, which includes:
 - Meal planning, preparation, clean-up
- Provision of assistance with safety, which includes:
 - Use of the principles of health and safety in relation to self and individual
 - Identifying and eliminating safety hazards
 - Practicing health protection and cleanliness by appropriate techniques of hand washing
 - Waste disposal and household tasks
 - Reminding individuals to self-administer medications
 - Providing assistance with correspondence and bill paying
 - Escorting individuals to community activities that are therapeutic in nature or that assist with developing and maintaining natural supports

Service Standards

- Attendant care services must follow a written service plan addressing specific needs determined by the individual's assessment

- If direct care or supervision of care is not provided to the client and the documentation of services rendered for the units billed reflects homemaker duties, an entry must be made to indicate why the direct care was not provided for that day. If direct care or supervision of care is not provided for more than 30 days and the documentation of services rendered for the units billed reflects homemaker duties, the case manager must be contacted to amend the service plan to:
 - Add homemaker services and eliminate attendant care services, or
 - Reduce attendant care hours and replace with the appropriate number of hours of homemaker services.

Documentation Standards

- Need must be identified in the service plan.
- Services must be outlined in the service plan.
- Data record of services must be provided, including:
 - Complete date and time of service (in and out)
 - Specific services or tasks provided
 - Signature of employee providing the service (minimally the last name and first initial)
 - If the person providing the service is required to be a professional, the title of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.
- Documentation of service delivery is to be signed by the participant or designated participant representative.

Activities Not Allowed

- Attendant care services will not be provided to medically unstable individuals as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, or other health professional
- Attendant care services will not be provided to household members other than to the participant
- Attendant care services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the healthcare representative (HCR) of a participant, or the legal guardian of a participant
- Attendant care services to participants receiving adult family care waiver service, structured family caregiving waiver service, or assisted living waiver service

Provider Qualifications

Table 7.4 – Provider Qualifications Table for Attendant Care

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	Licensed Home Health Agency	IC 16-27-1 IC 16-27-4	DA approved
A&D, TBI	Licensed Personal Services Agency	IC 16-27-4	DA approved
A&D, TBI	FSSA/DA approved Attendant Care	IC 16-27-4	DA approved 455 IAC 2 Provider Qualifications; General requirements

Section 7: Service Definitions

Waiver	Provider	Licensure/ Certification	Other Standard
	Individual		<p>455 IAC 2 General requirements for direct care staff</p> <p>455 IAC 2 Liability insurance</p> <p>455 IAC 2 Professional qualifications and requirements</p> <p>455 IAC 2 Personnel Records</p> <p>The division may reject any applicant with a conviction of a crime against persons or property, a conviction for fraud or abuse in any federal, state, or local government program, (42 USC §1320a-7) or a conviction for illegal drug possession. The division may reject an applicant convicted of the use, manufacture, or distribution of illegal drugs (42 USC §1320a-7). The division may reject an applicant who lacks the character and fitness to render services to the dependent population or whose criminal background check shows that the applicant may pose a danger to the dependent population. The division may limit an applicant with a criminal background to caring for a family member only if the family member has been informed of the criminal background.</p> <p>Compliance with IC 16-27-4, if applicable.</p>

Behavior Management/Behavior Program and Counseling

Service Definition

Behavior management includes training, supervision, or assistance in appropriate expression of emotions and desires, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors.

Behavior plans must be developed, monitored, and amended by a master's level psychologist or a master's in special education, supervised by an individual with a Ph.D. in behavioral science. Persons providing behavior management/behavior program and counseling who are employed by a qualified agency must be a Master's level behaviorist; a Certified Brain Injury Specialist (CBIS); a Qualified Intellectual Disability Professional ; or a Certified Social Worker who is supervised by a Master's level behaviorist. An individual practitioner providing this service must be a Master's level behaviorist.

Allowable Activities

- Observation of the individual and environment for purposes of development of a plan and to determine baseline
- Development of a behavioral support plan and subsequent revisions
- Training in assertiveness
- Training in stress reduction techniques
- Training in the acquisition of socially accepted behaviors
- Training staff, family members, roommates, and other appropriate individuals implementation of the behavior support plan
- Consultation with members
- Consultation with health service provider in psychology (HSPP)

Service Standards

- Behavior management/behavior program and counseling services must follow a written service plan addressing specific needs determined by the individual's assessment
- The behavior specialist will observe the individual in his or her own environment and develop a specific plan to address identified issues.
- The efficacy of the plan must be reviewed not less than quarterly and adjusted as necessary.
- The behavior specialist will provide a written report to pertinent parties at least quarterly. "Pertinent parties" include the individual, guardian, waiver case manager, all service providers, and other involved entities.

Documentation Standards

- Identified need in the service plan
- Services outlined in the service plan
- Service plan must have the identified level clinician
- Behavioral support plan
- Data record of clinician service documenting the date and time of service, and the number of units of service delivered that day with the service type

Activities Not Allowed

- Aversive techniques
- Any techniques not approved by the individual's person-centered planning team and the Division of Aging
- Behavior management/behavior program and counseling services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the healthcare representative (HCR) of a participant, or the legal guardian of a participant.

Provider Qualifications

Table 7.5 – Provider Qualifications Table for Behavior Management/Behavior Program and Counseling

Waiver	Provider	Licensure/ Certification	Other Standard
TBI	FSSA/DA Approved Behavior Management/ Behavior Program and Counseling Individual	Not required	DA approved 455 IAC 2 Provider Qualifications; General requirements 455 IAC 2 General requirements for direct care staff 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements 455 IAC 2 Personnel Records An individual practitioner providing this service must be a master's level behaviorist.
TBI	FSSA/DA approved Behavior Management/ Behavioral Program and Counseling Agency	Not required	DA approved 455 IAC 2 Provider Qualifications; General requirements 455 IAC 2 General requirements for direct care staff 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements 455 IAC 2 Personnel Records

Case Management

Service Definition

Case management is a comprehensive service comprising a variety of specific tasks and activities designed to coordinate and integrate all other services required in the individual's service plan.

Allowable Activities

- Assessments of eligible individuals to determine eligibility for services, functional impairment level, and corresponding in-home and community-based services needed by the individual
- Development of service plans to meet the individual's needs
- Implementation of the service plans linking individual with needed services, regardless of the funding source
- Assessment and care planning for discharge from institutionalization
- Annual and quarterly face-to-face reassessments of individual's needs
- Periodic updates of care plans
- Monitoring of the quality of home care community services provided to the individual
- Determination of and monitoring the cost effectiveness of providing in-home and community-based services
- Information and assistance services
- Enhancement or termination of services based on need
- Administrative guidance as described in Appendix E-1-j of the waiver application for participants who have selected self-directed attendant care

Service Standards

Case management services must be reflected in the service plan of the individual. Services must address needs identified in the service plan.

Documentation Standards

- Must be an approved provider.
- Must provide documentation identifying the provider as the case manager of record for the individual. (The pick list is appropriate documentation.)
- Must document all activities on behalf of individual being served within seven days of service.

Clinical/progress documentation standards for case management include:

- Services must be outlined in the service plan.
- Evidence must be provided that individual requires the level of service.
- Documentation to support services rendered must be provided.
- Case manager must ensure that the LOC review form is sent to the participant or applicant within 10 working days of the issue date and must document in the electronic case management database system the date the LOC review form was delivered.

Activities Not Allowed

Section 7: Service Definitions

- Case management may not be conducted by any organization, entity, or individual that also delivers other in-home and community-based services, or by any organization, entity, or individual related by common ownership or control to any other organization, entity, or individual who also delivers other in-home and community-based services, unless the organization is an Area Agency on Aging that has been granted permission by the Family and Social Services Administration Division of Aging to provide direct services to individuals.

Note: Common ownership exists when an individual, individuals, or any legal entity possess ownership or equity of at least 5% in the provider entity, as well as the institution or organization serving the provider. Control exists where an individual or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. Related means associated or affiliated with, or having the ability to control, or be controlled by.

- Independent case managers and independent case management companies may not provide initial applications for Medicaid waiver services.
- Reimbursement of case management under Medicaid waivers may not be made unless and until the individual becomes eligible for Medicaid waiver services. Case management provided to individuals who are not eligible for Medicaid waiver services will not be reimbursed as a Medicaid waiver service.
- Case management services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in fact (POA) of a participant, or the HCR of a participant, or the legal guardian of a participant.

Provider Qualifications

Table 7.6 – Provider Qualifications Table for Case Management

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	FSSA/DA Approved Case Management Individual	Not required	<p>DA, or its designee, approved</p> <p>455 IAC 2 Documentation of qualifications</p> <p>455 IAC 2 Case Management</p> <p>Liability Insurance</p> <p>Training in the nursing facility level of care process by the Division of Aging or designee</p> <p>Education and work experience:</p> <ul style="list-style-type: none"> A Qualified Intellectual Disability Professional who meets the requirements at 42 CFR 483.430 A registered nurse with one year's experience in human services A bachelor's degree in social work, psychology, sociology, counseling, gerontology, or nursing; health and human services A bachelor's degree in any field with a minimum of two years of full-time, direct-service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring)

Waiver	Provider	Licensure/ Certification	Other Standard
			<ul style="list-style-type: none"> A master's degree in a related field may substitute for the required experience
A&D	FSSA/DA approved Case Management Agency	Not required	<p>DA, or its designee, approved</p> <p>455 IAC 2 Provider Qualifications; General requirements</p> <p>455 IAC 2 General requirements for direct care staff</p> <p>455 IAC 2 Procedures for protecting individuals</p> <p>455 IAC 2 Unusual occurrence; reporting</p> <p>455 IAC 2 Transfer of individual's record upon change of provider</p> <p>455 IAC 2 Notice of termination of services</p> <p>455 IAC 2 Provider organizational chart</p> <p>455 IAC 2 Collaboration and quality control</p> <p>455 IAC 2 Data collection and reporting standards</p> <p>455 IAC 2 Quality assurance and quality improvement system</p> <p>455 IAC 2 Financial information</p> <p>455 IAC 2 Liability insurance</p> <p>455 IAC 2 Documentation of qualifications</p> <p>455 IAC 2 Maintenance of personnel records</p> <p>455 IAC 2 Adoption of personnel policies</p> <p>455 IAC 2 Operations manual</p> <p>455 IAC 2 Maintenance of records of services provided</p> <p>455 IAC 2 Individual's personal file; site of service delivery</p> <p>455 IAC 2 Maintenance of records of services provided</p> <p>455 IAC 2 Case Management</p> <p>Training in the nursing facility level of care process by the Division of Aging or designee – education and work experience:</p> <ul style="list-style-type: none"> An individual continuously employed as a case manager by an Area Agency on Aging (AAA) since January 1, 1990 A Qualified Intellectual Disability Professional who meets the requirements at 42 CFR 483.430 A registered nurse with one year's experience in human services; or <ul style="list-style-type: none"> A bachelor's degree in social work, psychology, sociology, counseling, gerontology, nursing or health and human services; or A bachelor's degree in any field with a minimum of two years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring); or A master's degree in a related field may substitute for the required experience
TBIA	FSSA/DA approved Case Management Agency	Not Required	<p>DA, or its designee, approved</p> <p>455 IAC 2 Provider Qualifications; General requirements</p> <p>455 IAC 2 General requirements for direct care staff</p> <p>455 IAC 2 Procedures for protecting individuals</p> <p>455 IAC 2 Unusual occurrence; reporting</p>

Section 7: Service Definitions

Waiver	Provider	Licensure/ Certification	Other Standard
			<p>455 IAC 2 Transfer of individual's record upon change of provider</p> <p>455 IAC 2 Notice of termination of services</p> <p>455 IAC 2 Provider organizational chart</p> <p>455 IAC 2 Collaboration and quality control</p> <p>455 IAC 2 Data collection and reporting standards</p> <p>455 IAC 2 Quality assurance and quality improvement system</p> <p>455 IAC 2 Financial information</p> <p>455 IAC 2 Liability insurance</p> <p>455 IAC 2 Documentation of qualifications</p> <p>455 IAC 2 Maintenance of personnel records</p> <p>455 IAC 2 Adoption of personnel policies</p> <p>455 IAC 2 Operations manual</p> <p>455 IAC 2 Maintenance of records of services provided</p> <p>455 IAC 2 Individual's personal file; site of service delivery</p> <p>455 IAC 2 Maintenance of records of services provided</p> <p>455 IAC 2 Individual's personal file; site of service delivery</p> <p>455 IAC 2 Case Management</p> <p>Education and work experience</p> <ul style="list-style-type: none"> • A Qualified Intellectual Disability Professional who meets the requirements at 42 CFR 483.430 • A registered nurse with one year's experience in human services; or <ul style="list-style-type: none"> – A bachelor's degree in social work, psychology, sociology, counseling, gerontology, or nursing; or – A bachelor's degree in any field with a minimum of two years of full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring); or – A master's degree in a related field may substitute for the required experience

Community Transition

Service Definition

Community transition services include reasonable setup expenses for individuals who make the transition from an institution to their own home where the person is directly responsible for his or her own living expenses in the community and will not be reimbursable on any subsequent move.

Note: “Own home” is defined for this service as any dwelling, including a house, an apartment, a condominium, a trailer, or other lodging that is owned, leased, or rented by the individual or the individual’s guardian or family, or a home that is owned or operated by the agency providing supports.

Items purchased through community transition are the property of the individual receiving the service, and the individual takes the property with him or her in the event of a move to another residence, even if the residence from which he or she is moving is owned by a provider agency. Nursing facilities are not reimbursed for community transition because those services are part of the *per diem*. For those receiving this service under the waiver, reimbursement for approved community transition expenditures are reimbursed through the local AAA.

Allowable Activities

- Security deposits that are required to obtain a lease on an apartment or home
- Essential furnishings and moving expenses required to occupy and use a community domicile including a bed, table or chairs, window coverings, eating utensils, food preparation items, microwave, and bed or bath linens
- Setup fees or deposits for utility or service access including telephone, electricity, heating, and water
- Health and safety assurances including pest eradication, allergen control, or one-time cleaning prior to occupancy

Service Standards

Community transition services must follow a written service plan addressing specific needs determined by the individual’s assessment.

Documentation Standards

- Identified need in the service plan
- Services outlined in the service plan
- Documentation requirements include maintaining receipts for all expenditures, showing the amount and what item or deposit was covered

Limitations

Reimbursement for community transition is limited to a lifetime cap for setup expenses, up to \$1,500.

Activities Not Allowed

- Apartment or housing rental or mortgage expenses
- Food
- Appliances
- Diversional or recreational items such as hobby supplies
- Television
- Cable TV access
- VCRs
- Regular utility charges
- Services to participants receiving adult family care waiver service

Provider Qualifications

Table 7.7 – Provider Qualifications Table for Community Transition

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	FSSA/DA Approved Community Transition Service Agency	Not required	DA approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider qualifications: General requirements 455 IAC 2 Transfer of individual's record upon change of provider 455 IAC 2 Financial information 455 IAC 2 Liability insurance 455 IAC 2 Transportation of an individual 455 IAC 2 Professional qualifications and requirements; documentation of qualifications 455 IAC 2 Maintenance of personnel records 455 IAC 2 Adoption of personnel policies 455 IAC 2 Operations manual 455 IAC 2 Maintenance of records of services provided 455 IAC 2 Individual's personal file; site of service delivery

Environmental Modifications

Service Definition

Environmental modifications are minor physical adaptations to the home, as required by the individual's service plan which are necessary to ensure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Home Ownership

Environmental modifications shall be approved for the individual's own home or family-owned home. Rented homes or apartments are allowed to be modified only when a signed agreement from the landlord is obtained. The signed agreement must be submitted along with all other required waiver documentation.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is a strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

All environmental modifications must be approved by the waiver program prior to services are rendered.

- Environmental modification requests must be provided in accordance with applicable State or local building codes and should be guided by *Americans with Disability Act (ADA)* or *ADA Accessibility Guidelines (ADAAG)* requirements when in the best interest of the individual and his or her specific situation.
- Environmental modifications shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:
 - The modification is the most cost effective or conservative means to meet the individual's needs for accessibility within the home.
 - The environmental modification is individualized, specific, and consistent with, but not in excess of, the individual's needs.
- Requests for modifications at two or more locations may only be approved at the discretion of the DA director or designee.
- Requests for modifications may be denied if the State division director or State agency designee determines that the documentation does not support residential stability or the service requested.

Allowable Activities

Justification and documentation is required to demonstrate that the modification is necessary to meet the individual's identified needs.

- Adaptive door openers and locks – Limited to one per individual primary residence for an individual living alone or who is alone without a caregiver for substantial periods of time but needs to open, close, or lock the doors and cannot do so without special adaptation.

Section 7: Service Definitions

- Bathroom modification – Limited to one existing bathroom per individual primary residence when no other accessible bathroom is available. The bathroom modification may include:
 - Removal of existing bathtub, toilet, or sink
 - Installation of roll in shower, grab bars, ADA toilet, and wall-mounted sink
 - Installation of replacement flooring, if necessary due to bath modification
- Environmental control units – Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.
- Environmental safety devices limited to:
 - Door alarms
 - Antiscald devices
 - Hand-held shower head
 - Grab bars for the bathroom
- Fence – Limited to 200 linear feet (individual must have a documented history of elopement)
- Ramp – Limited to one per individual primary residence and only when no other accessible ramp exists:
 - In accordance with the ADA or ADAAG, unless this is not in the best interest of the client
 - Portable – Considered for rental property only
 - Permanent
 - Vertical lift – May be considered in lieu of a ramp if there is photographic and written documentation that shows it is not possible for a ramp to be used
- Stair lift – If required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per service plan.
- Single-room air conditioners/single-room air purifiers – If required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per service plan:
 - There is a documented medical reason for the individual's need to maintain a constant external temperature. The documentation necessary for this equipment includes a prescription from the primary care physician.
 - The room air conditioner size is consistent with the room size (square feet) capacity to be cooled.
- Widen doorway – To allow safe egress:
 - Exterior – Modification limited to one per individual primary residence when no other accessible door exists.
 - Interior – Modification of bedroom, bathroom, or kitchen door or doorway as needed to allow for access. (A pocket door may be appropriate when there is insufficient room to allow for the door swing.)
- Windows – Replacement of glass with Plexiglas® or other shatterproof material when there is a documented medical/behavioral reason.
- Upon the completion of the modification, painting, wall coverings, doors, trim, flooring, and so forth will be matched (to the degree possible) to the previous color/style/design.
- Maintenance – Limited to \$500 annually for the repair and service of environmental modifications that have been provided through an HCBS waiver:
 - Requests for service must detail parts cost and labor cost.
 - If the need for maintenance exceeds \$500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a non-waiver funding source.

- Items requested that are not listed above must be reviewed and decision rendered by the State division director or State agency designee.

Service Standards

- Environmental modification must be of direct medical or remedial benefit to the individual.
- Environmental modifications must meet applicable standards of manufacture, design, and installation and should be guided by ADA or ADAAG requirements when in the best interest of the individual and his or her specific situation.
- Environmental modifications must be compliant with applicable building codes.

Documentation Standards

- The identified direct benefit or need must be documented within a:
 - Service plan
 - Physician prescription and/or clinical evaluation, as deemed appropriate
- Documentation/explanation of the service within the Request for Approval to Authorize Services (RFA) including the following:
 - Property owner of the residence where the requested modification is proposed
 - Property owner's relationship to the individual
 - What, if any, relationship the property owner has to the waiver program
 - Length of time the individual has lived at this residence
 - If a rental property, length of lease
 - Written agreement of landlord for modification
 - Verification of individual's intent to remain in the setting
 - Land survey may be required when exterior modifications approach property line
- Signed and approved RFA
- Signed and approved service plan
- Provider of services required to maintain receipts for all incurred expenses related to the modification
- Must be in compliance with FSSA- and division-specific guidelines and policies

Limitations

A lifetime cap of \$15,000 is available for environmental modifications. The cap represents a cost for basic modification of an individual's home for accessibility and safety, and accommodates the individual's needs for housing modifications. The cost of an environmental modification includes all materials, equipment, labor, and permits to complete the project. No parts of an environmental modification may be billed separately as part of any other service category (for example, specialized medical equipment). In addition to the \$15,000 lifetime cap, \$500 is allowable annually for the repair, replacement, or an adjustment to an existing environmental modification that was funded by an HCBS waiver.

Activities Not Allowed

Examples and descriptions of activities not allowed include, but are not limited to the following:

- Adaptations or improvements that are not of direct medical or remedial benefit to the individual:
 - Central heating and air conditioning
 - Routine home maintenance

Section 7: Service Definitions

- Installation of standard (non-ADA, non-ADAAG) home fixtures (such as sinks, commodes, tub, wall, window and door coverings, and so forth) that replace existing standard (non-ADA, non-ADAAG) home fixtures
- Roof repair
- Structural repair
- Garage doors
- Elevators
- Ceiling track lift systems
- Driveways, decks, patios, sidewalks, or household furnishings
- Replacement of carpeting and other floor coverings
- Storage (such as cabinets, shelving, or closets), sheds
- Swimming pools, spas, or hot tubs
- Video monitoring system
- Adaptive switches or buttons to control devices intended for entertainment, employment, or education
- Home-security systems
- Modifications that create living space or facilities where they did not previously exist (such as installation of a bathroom in a garage or basement, and so forth).
- Modifications that duplicate existing accessibility (such as a second accessible bathroom, a second means of egress from home, and so forth).
- Modifications that will add square footage to the home.
- Individuals living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) are not eligible to receive this service.

Note: The responsibility for environmental modifications rests with the facility owner or operator.

- Individuals living in a provider-owned residence are not eligible to receive this service

Note: The responsibility for environmental modifications rests with the facility owner or operator.

- Completion of, or modifications to, new construction, or significant remodeling or reconstruction are excluded unless there is documented evidence of a significant change in the individual's medical or remedial needs that now require the requested modification.
- Services to participants receiving adult family care.
- Services to participants receiving assisted living.
- Environmental modification services will not be reimbursed when provided as an individual provider by a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the healthcare representative (HCR) of a participant, or the legal guardian of a participant.

Provider Qualifications

Table 7.8 – Provider Qualifications Table for Environmental Modifications

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	FSSA/DA- Approved Environmental Modification Individual	Any applicable licensure must be in place	DA approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider qualifications: General requirements 455 IAC 2 Maintenance of records of services provided 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements; documentation of qualifications 455 IAC 2 Warranty required Compliance with applicable building codes/ permits.
A&D, TBI	FSSA/DA- Approved Environmental Modification Agency/ Contractor	Any applicable licensure IC 25-20.2 Home inspector IC 25-28.5 Plumber Evaluator IC 25-23.5 Certification IC 25-4 Architect	DA approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider qualifications: General requirements 455 IAC 2 Maintenance of records of services provided 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements; documentation of qualifications 455 IAC 2 Warranty required Compliance with applicable building codes and permits
A&D, TBI	Plumber	IC 25-28.5	DA approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider qualifications: General requirements 455 IAC 2 Financial information 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements; documentation of qualifications 455 IAC 2 Warranty required Compliance with applicable building codes and permits
A&D, TBI	Architect	IC 25-4	DA approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider qualifications: General requirements 455 IAC 2 Financial information 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements; documentation of qualifications 455 IAC 2 Warranty required Compliance with applicable building codes and permits

Environmental Modification Assessment

Service Definition

Environmental modification assessment services will be used to objectively determine the specifications for an environmental modification that is safe, appropriate, and feasible in order to ensure accurate bids and workmanship.

The environmental modification assessment will assess the home for minor physical adaptations, which as indicated by individual's service plan, are necessary to ensure the health, welfare, and safety of the individual enable the individual to function with greater independence in the home and without which the individual would require institutionalization.

The assessor will be responsible for writing the specifications, reviewing of feasibility, and the post-project inspection. Upon completion of the specifications and review of feasibility, the assessor will prepare and submit the project specifications to the case manager and individual for the bidding process and will be paid the first installment of \$300 for completing of home specifications. After the project is complete, the assessor, consumer, and case manager will then inspect the work and sign off, indicating that it was completed per the agreed-upon bid and be paid the final installment of \$200. This payment is not included in the actual environmental modification cost category and shall not be subtracted from the participant's lifetime cap of \$15,000. The case management provider entity will be responsible for maintaining related records that can be accessed by the State.

Allowable Activities

- Evaluation of the current environment, including the identification of barriers that may prevent the completion of desired modifications
- Reimbursement for nonfeasible assessments
- Review of participant's plan of care
- Drafting of specifications: electrical, plumbing, and interior framing
- Preparation and submission of specifications
- Post-project inspection/approval

Service Standards

- Need for environmental modification must be indicated in the participant's plan of care
- Modification must address the participant's level of service needs
- Proposed specifications for modification must conform to the requirements and limitations of the current approved service definition for environmental modification services
- Assessment should be conducted by an approved, qualified individual who is independent of the entity providing the environmental modifications

Limitations

An annual cap of \$500 is available for environmental modification assessment services.

Activities Not Allowed

- Environmental modification assessment services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the

attorney-in-fact (POA) of a participant, the healthcare representative (HCR) of a participant, or the legal guardian of a participant.

- Payment will not be made for environmental modifications under this service.
- Payment will not be made for an environmental modification assessment for the maintenance, repair, or service of an existing environmental modification that was funded by a Home and Community-Based Services (HCBS) waiver.

Provider Qualifications

Table 7.9 – Provider Qualifications Table for Environmental Modification Assessor

Waiver	Provider	Licensure/ Certification	Other Standard
A&D,	FSSA/DA- Approved Environmental Modification Assessment Individual	License: IC 25- 20.2 Home Inspector OR: Certified Aging-In-Place Specialist (CAPS Certification – National Association of Home Builders) OR: Executive Certificate in Home Modifications (University of Southern California) AND: Verification required every three years	DA Approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider qualifications: General requirements 455 IAC 2 Financial information 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements; documentation of qualifications 455 IAC 2 Warranty required Compliance with applicable building codes and permits
A&D	Architect	License: IC 23-4 AND Frequency of verification up to every three years	DA Approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider qualifications: General requirements 455 IAC 2 Financial information 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements; documentation of qualifications 455 IAC 2 Warranty required Compliance with applicable building codes and permits

Healthcare Coordination

Service Definition

Healthcare coordination includes medical coordination provided by a registered nurse (RN) to manage the healthcare of the individual including physician consults, medication ordering, and development and nursing oversight of a healthcare support plan. Skilled nursing services are provided within the scope of the *Indiana State Nurse Practice Act*. The purpose of healthcare coordination is stabilization, delay/prevent deterioration of health status, management of chronic conditions, and/or improved health status. Health Care Coordination is open to any waiver participant whose needs demonstrate the need for such level of service without duplicating other formal and informal supports.

Because of the different benefits provided under Skilled Nursing and Health Care Coordination, Medicaid prior authorization for skilled nursing services is not necessary prior to the provision of healthcare coordination.

The appropriate level of healthcare coordination service should be determined by a healthcare professional (RN or doctor).

Allowable Activities

- Physician consultations
- Medication ordering
- Development and oversight of a healthcare support plan

Service Standards

- Weekly consultations or reviews
- Face-to-face visits with the individual
- Other activities, as appropriate
- Services must address needs identified in the service plan
- The provider of home healthcare coordination to provide a written report to pertinent parties at least quarterly
 - Pertinent parties include the individual, guardian, waiver case manager, all service providers, and other entities.

Documentation Standards

- Identified need in the service plan
- Services outlined in the service plan
- Current Indiana RN license for each nurse
- Evidence of a consultation, including complete date and signature; consultation can be with the individual, other staff, or other professionals, as well as healthcare professionals
- Evidence of a face-to-face visit with the individual, including complete date and signature

Limitations

Healthcare coordination services will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Healthcare coordination services are:

- A minimum of one face-to-face visit per month
- Not to exceed eight hours of healthcare coordination per month

Activities Not Allowed

- Skilled nursing services that are available under the Medicaid State Plan
- Services to participants receiving assisted living waiver service
- Any other service otherwise provided by the waiver

Provider Qualifications

Table 7.10 – Provider Qualifications Table for Health Care Coordination

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	Licensed Home Health Agency	IC 16-27-1 Home Health Agency IC 25-23-1 RN	DA approved

Home-Delivered Meals

Service Definition

A home-delivered meal is a nutritionally balanced meal. This service is essential in preventing institutionalization because the absence of proper nutrition in individuals with frail and disabling conditions presents a severe risk to health. No more than two meals per day will be reimbursed under the waiver.

Allowable Activities

- Provision of meals
- Diet and nutrition counseling provided by a registered dietician
- Nutritional education
- Diet modification according to a physician's order, as required, meeting the individual's medical and nutritional needs

Service Standards

- Home-delivered meals services must follow a written service plan addressing specific needs determined by the individual's assessment.
- Home-delivered meals will be provided to persons who are unable to prepare their own meals and for whom there are no other persons available to do so; or where the provision of a home-delivered meal is the most cost-effective method of delivering a nutritionally adequate meal, and it is not otherwise available through other funding sources.
- All home-delivered meals provided must contain at least one-third of the current Recommended Dietary Allowance (RDA), as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council.
- All meals must meet state, local, and federal laws and regulations regarding the safe handling of food. The provider must also hold adequate and current Servsafe Certification.

Documentation Standards

- Identified need in the service plan
- Services outlined in the service plan
- Date of service and units of service documented

Activities Not Allowed

- No more than two meals per day to be reimbursed under the waiver
- Services to participants receiving structured family caregiving waiver service
- Services to participants receiving adult family care waiver service
- Services to participants receiving assisted living waiver service

Provider Qualifications

Table 7.11 – Provider Qualifications Table for Home Delivered Meals

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	FSSA/DA- Approved Home Delivered Meals Agency	Not required	DA approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider qualifications: General requirements 455 IAC 2 Maintenance of records of services provided 455 IAC 2 Liability insurance 455 IAC 2 Maintenance of records of services provided Must comply with all state and local health laws and ordinances concerning preparation, handling, and serving of food.

Homemaker Services

Service Definition

Homemaker services offer direct and practical assistance consisting of household tasks and related activities. Homemaker services assist the individual to remain in a clean, safe, and healthy home environment. Homemaker services are provided when the individual is unable to meet these needs or when an informal caregiver is unable to meet these needs for the individual.

Allowable Activities

- Provision of housekeeping tasks, which include:
 - Dusting and straightening furniture
 - Cleaning floors and rugs by wet or dry mop and vacuum sweeping
 - Cleaning the kitchen, including washing dishes, pots, and pans; cleaning the outside of appliances and counters and cupboards; cleaning ovens and defrosting and cleaning refrigerators
 - Maintaining a clean bathroom, including cleaning the tub, shower, sink, toilet bowl, and medicine cabinet; emptying and cleaning the commode chair or urinal
 - Laundering clothes in the home or laundromat, including washing, drying, folding, putting away, ironing, and basic mending and repair
 - Changing linen and making beds
 - Washing insides of windows
 - Removing trash from the home
 - Choosing appropriate procedures, equipment, and supplies; improvising when there are limited supplies, keeping equipment clean and in its proper place
 - Clearing primary walk-ways
- Provision of assistance with meals or nutrition, which includes:
 - Shopping, including planning and putting food away
 - Making meals, including special diets under the supervision of a registered dietitian or health professional
- Running the following essential errands:
 - Grocery shopping
 - Household supply shopping
 - Prescription pickup
- Provision of assistance with correspondence and bill-paying

Service Standards

Homemaker services must follow a written service plan addressing specific needs determined by the client's assessment.

Documentation Standards

- Identified need in the service plan
- Services outlined in the service plan

- Data record of services provided, including:
 - Complete date and time of service (in and out).
 - Specific services and tasks provided.
 - Signature of employee providing the service (minimally the last name and first initial). If the person providing the service is required to be a professional, the title of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.
- Documentation of service delivery is to be signed by the participant or designated participant representative.

Activities Not Allowed

- Assistance with hands-on services such as eating, bathing, dressing, personal hygiene, and activities of daily living.
- Escorting or transporting individuals to community activities or errands.
- Homemaker services provided to household members other than to the participant.
- Cleaning up of the yard, defined as lawn mowing, raking leaves.
- Homemaker services will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the healthcare representative (HCR) of a participant, or the legal guardian of the participant, or by any member of the participant's household.
- Services to participants receiving adult family care waiver service, structured family caregiving waiver service, or assisted living waiver service.

Provider Qualifications

Table 7.12 – Provider Qualifications Table for Homemaker Services

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	Licensed Personal Services Agency	IC 16-27-4	DA approved
A&D, TBI	FSSA/DA- Approved Homemaker Individual	Not required	DA approved 455 IAC 2 Provider qualifications: becoming an approved provider; maintaining approval 455 IAC 2 Provider qualifications: general requirements 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements 455 IAC 2 Personnel records Compliance with IC 16-27-4, if applicable.
A&D, TBI	Licensed Home Health Agency	IC 16-27-1 IC 16-27-4	DA approved

Nutritional Supplements

Service Definition

Nutritional (dietary) supplements include liquid supplements, such as Boost® or Ensure® to maintain an individual's health in order to remain in the community.

Supplements should be ordered by a physician based on specific life stage, gender, or lifestyle.

Reimbursement for approved nutritional supplement expenditures is reimbursed through the local AAA that maintains all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid Agency at their election.

Allowable Activities

Enteral Formulae, category 1, such as Boost or Ensure.

Service Standards

Nutritional supplement services must follow a written service plan addressing specific needs determined by the individual's assessment.

Documentation Standards

- Identified need in the service plan
- Services outlined in the service plan
- Documentation to support services rendered

Limitations

An annual cap of \$1,200 is available for nutritional supplement services.

Activities Not Allowed

- Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service)
- Services to participants receiving adult family care waiver service
- Services to participants receiving assisted living waiver service

Provider Qualifications

Table 7.13 – Provider Qualifications Table for Nutritional Supplements

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	FSSA/DA- Approved Nutritional Supplements Agency	Not required	DA approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider qualifications: General requirements 455 IAC 2 Transfer of individual's record upon change of provider

Waiver	Provider	Licensure/ Certification	Other Standard
			455 IAC 2 Maintenance of records of services provided 455 IAC 2 Liability insurance 455 IAC 2 Individual's personal file; site of service delivery

Personal Emergency Response System

Service Definition

Personal emergency response system (PERS) is an electronic device that 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 telephone and programmed to signal a response center once a "help" button is activated. The response center is staffed 24 hours a day, seven days per week by trained professionals.

Allowable Activities

- PERS 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 supervision
- Device installation service
- Ongoing monthly maintenance of device

Service Standards

Personal emergency response services must follow a written service plan addressing specific needs determined by the individual's assessment.

Documentation Standards

- Identified needs in the service plan
- Services outlined in the service plan
- Documentation of expense for installation
- Documentation of monthly rental fee

Activities Not Allowed

- The replacement cost of lost or damaged equipment.
- Reimbursement is not available for PERS supports when the individual requires constant supervision to maintain health and safety.
- Services to participants receiving adult family care waiver service, structured family care waiver service, or assisted living waiver service.

Provider Qualifications

Table 7.14 – Provider Qualifications Table for Personal Emergency Response System

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	FSSA/DA- Approved Personal Emergency Response System Agency	Not required	DA approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider qualifications: General requirements 455 IAC 2 Maintenance of records of services provided 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements; documentation of qualifications 455 IAC 2 Warranty required Compliance with applicable building codes and permits

Pest Control

Service Definition

Pest control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans, or annoys humans, and is causing or is expected to cause more harm than is reasonable to accept. Pests include insects such as roaches, mosquitoes, and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice.

Services to control pests are services that prevent, suppress, or eradicate pest infestation.

Reimbursement for approved pest control expenditures is reimbursed through the local AAA who maintains all applicable receipts and verifies the delivery of services. Providers can directly relate to the State Medicaid agency at their election.

Allowable Activities

Pest control services are added to the service plan when the case manager determines through direct observation or client report that a pest is present that is causing or is expected to cause more harm than is reasonable to accept. Services to control pests are services that suppress or eradicate pest infestation.

Service Standards

Pest control services must follow a written service plan addressing specific needs determined by the individual's assessment.

Documentation Standards

- Identified need in the service plan
- Services outlined in the service plan
- Receipts of specific service, date of service, and cost of service completed

Limitations

An annual cap of \$600 is available for pest control services.

Activities Not Allowed

- Pest control services may not be used solely as a preventative measure; there must be documentation of a need for this service either through a care manager's direct observation or individual report that a pest is causing or is expected to cause more harm than is reasonable to accept.
- Services to participants receiving adult family care waiver service.
- Services to participants receiving assisted living waiver service.

Provider Qualifications

Table 7.15 – Provider Qualifications Table for Pest Control

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	FSSA/DA- Approved Pest Control Agency	IC 15-3-3.6	<p>DA approved</p> <p>455 IAC 2 Becoming an approved provider; maintaining approval</p> <p>455 IAC 2 Provider qualifications: General requirements</p> <p>455 IAC 2 Maintenance of records of services provided</p> <p>455 IAC 2 Liability insurance</p> <p>455 IAC 2 Professional qualifications and requirements; documentation of qualifications</p> <p>455 IAC 2 Warranty required</p> <p>Pesticide applicators must be certified or licensed through the Purdue University Extension Service and the Office of the Indiana State Chemist.</p>

Residential-Based Habilitation

Service Definition

Residential-based habilitation service provides training to regain skills that were lost secondary to the traumatic brain injury (TBI).

Allowable Activities

Goal-oriented training and demonstration with:

- Skills related to activities of daily living:
 - Personal grooming
 - Bed making and household chores
 - Planning meals, the preparation of food
- Skills related to living in the community:
 - Using the telephone
 - Learning to prepare lists and maintaining calendars of essential activities and dates, and other organizational activities to improve memory
 - Handling money and paying bills
 - Shopping and errands
 - Accessing public transportation

Service Standards

Residential-based habilitation services must follow a written service plan addressing specific measurable goals and objectives to help with the acquisition, retention, or improvement of skills that were lost secondary to the TBI.

Residential-based habilitation services must be monitored monthly.

Documentation Standards

- Identified need in the service plan
- Services outlined in the service plan
- A data record of services provided, including:
 - Complete date and time of service (in and out)
 - Specific services/tasks provided
- Monthly documentation of progress toward identified goals
- Signature of employee providing the service (minimally the last name and first initial). If the person providing the service is required to be a professional, the title of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.
- Documentation of service delivery is to be signed by the participant or designated participant representative.

Limitations

Services provided through residential-based habilitation service will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Activities Not Allowed

- Payments for residential-based habilitation are not made for room and board.
- Payment for residential-based habilitation does not include payments made directly or indirectly when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the healthcare representative (HCR) of a participant, or the legal guardian of a participant.
- Payments will not be made for routine care and supervision.
- Residential-based habilitation services to participants receiving adult family care waiver service.

Provider Qualifications

Table 7.16 – Provider Qualifications Table for Residential Based Habilitation

Waiver	Provider	Licensure/ Certification	Other Standard
TBI	FSSA/DA- Approved Residential Based Habilitation Agency	Not required	<p>DA approved</p> <p>455 IAC 2 Provider qualifications; general requirements</p> <p>455 IAC 2 General requirements for direct care staff</p> <p>455 IAC 2 Liability insurance</p> <p>455 IAC 2 Professional qualifications and requirements</p> <p>455 IAC 2 Personnel records</p> <p>Habilitation services must be performed by persons who are supervised by a CBIS or Qualified Intellectual Disability Professional; or a physical, occupational, or speech therapist licensed by the state of Indiana who have successfully completed training or have experience in conducting habilitation programs.</p>

Respite Services

Service Definition

Respite services are services that are provided temporarily or periodically in the absence of the usual caregiver. Service may be provided in the following locations:

- In an individual's home
- In the private home of the caregiver

The level of professional care provided under respite services depends on the needs of the individual.

- An individual requiring assistance with the following:
 - Bathing
 - Meal preparation and planning
- Specialized feeding, such as an individual who:
 - Has difficulty swallowing
 - Refuses to eat
 - Does not eat enough
- Dressing or undressing
- Hair and oral care
- Weight-bearing transfer assistance should be considered for a respite home health aide under the supervision of a registered nurse
- Individuals requiring infusion therapy; venipuncture; injection; wound care for surgical, decubitus; incision; ostomy care; or tube feedings should be considered for respite nursing services

Allowable Activities

- Home health aide services
- Skilled nursing services

Service Standards

- Respite services must follow a written service plan addressing specific needs determined by the individual's assessment
- The level of care and type of respite will not exceed the requirements of the service plan; therefore, skilled nursing services will only be provided when the needs of the individual warrant skilled care
- If an individual's needs can be met with an LPN, but an RN provides the service, the service may only be billed at the LPN rate.

Documentation Standards

- Identified need in the service plan
- Services outlined in the service plan
- Documentation must include the following elements:
 - Reason for the respite
 - Location where the service was rendered
 - Type of respite rendered
- Data record of staff to individual service, documenting the complete date and time in and time out, and the number of units of service delivered that day. Each staff member providing direct care or

supervision of care to the individual makes at least one entry on each day of service describing an issue or circumstance concerning the individual

- Documentation should include date and time, and at least the last name and first initial of the staff person making the entry. If the person providing the service is required to be a professional, the title of the individual must also be included. (Example: If a nurse is required to perform the service, the RN title would be included with the name.) Any significant issues involving the individual requiring intervention by a healthcare professional or case manager that involve the individual also need to be documented

Activities Not Allowed

- Respite shall not be used as day/child care to allow the persons normally providing care to go to work
- Respite shall not be used as day/child care to allow the persons normally providing care to attend school
- Respite shall not be used to provide service to a participant while participant is attending school
- Respite may not be used to replace services that should be provided under the Medicaid State Plan
- Respite will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the healthcare representative (HCR) of a participant, or the legal guardian of a participant
- Respite must not duplicate any other service being provided under the participant's POC
- Services to participants receiving adult family care waiver service
- Services to participants receiving assisted living waiver service
- Services to participants receiving structured family caregiving service

Provider Qualifications

Table 7.17 – Provider Qualifications Table for Respite

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	Licensed Home Health Agency	IC 16-27-1	DA approved

Specialized Medical Equipment and Supplies

Service Definition

Specialized medical equipment and supplies are medically prescribed items required by the individual's service plan, which are necessary to assure the health, welfare, and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

All specialized medical equipment and supplies must be approved by the waiver program prior to the service being rendered.

- Individuals requesting authorization for this service through HCBS waivers must first exhaust eligibility of the desired equipment or supplies through the Medicaid State Plan, which may require prior authorization (PA).
 - There should be no duplication of services between HCBS waiver and Medicaid State Plan.
 - The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Medicaid State Plan is not a justification for waiver purchase.
 - Preference for a specific brand name is not a medically necessary justification for waiver purchase. The Medicaid State Plan often covers like equipment but may not cover the specific brand requested. When this occurs, the individual is limited to the Medicaid State Plan covered service or brand.
 - Reimbursement is limited to the Medicaid State Plan fee schedule, if the requested item is covered under Medicaid State Plan.
 - All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Medicaid State Plan PA request and decision, if the requested item is covered under the Medicaid State Plan.
- Specialized medical equipment and supplies shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:
 - The request is the most cost-effective or conservative means to meet the individual's specific needs.
 - The request is individualized, specific, and consistent with, but not in excess of, the individual's needs.
- Requests will be denied if the DA director or designee determines the documentation does not support the service requested.

Allowable Activities

Justification and documentation is required to demonstrate that the request is necessary to meet the individual's identified needs:

- Communication devices – Computer adaptations for keyboard, picture boards, and so forth. The Request for Approval (RFA) must be accompanied by documentation of a Medicaid State Plan PA request and the decision rendered under the Medicaid State Plan.
- Generators (portable) – When ventilator, daily use of oxygen via a concentrator, continuous infusion of nutrition (tube feeding), or medication through an electric pump are medical requirements of the individual. The generator is limited to the kilo-wattage necessary to provide power to the essential life-sustaining equipment, and is limited to one generator per individual per ten-year period.

- Interpreter service – Provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (for example, waiver case conferences and team meetings) and is not available to facilitate communication for other service provision.
- Self-help devices – Including over-the-bed tables, reachers, adaptive plates, bowls, cups, drinking glasses, and eating utensils that are prescribed by a physical therapist or occupational therapist.
- Strollers – When needed because the individual's primary mobility device does not fit into the individual's vehicle/mode of transportation, or when the individual does not require the full-time use of a mobility device, but a stroller is needed to meet the mobility needs of the individual outside of the home setting. The RFA must be accompanied by documentation of a Medicaid State Plan PA request and the decision rendered under the Medicaid State Plan.
- Manual wheelchairs – When required to facilitate safe mobility. The RFA must be accompanied by documentation of a Medicaid State Plan PA request and the decision rendered under the Medicaid State Plan.
- Maintenance – Limited to \$500 annually for the repair and service of items that have been provided through an HCBS waiver. Items that were previously purchased through the waiver, but not listed in allowable activities, will continue to be maintained according to the definition.
 - Requests for service must detail parts and labor costs
 - If the need for maintenance exceeds \$500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.
- Posture chairs and feeding chairs – As prescribed by a physician, occupational therapist, or physical therapist. The RFA must be accompanied by documentation of a Medicaid State Plan PA request and the decision rendered under the Medicaid State Plan.

Service Standards

- Specialized medical equipment and supplies must be of direct medical or remedial benefit to the individual.
- All items shall meet applicable standards of manufacture, design, and service specifications.

Documentation Standards

Documentation standards include the following:

- The identified direct benefit or need must be documented within:
 - Service plan
 - Physician prescription and clinical evaluation, as deemed appropriate
- Medicaid State Plan prior authorization request and the decision rendered, if applicable
- Signed and approved RFA to Authorize Services
- Signed and approved service plan
- Provider of services must maintain receipts for all incurred expenses related to this service
- Must be in compliance with FSSA- and division-specific guidelines and policies.

Limitations

Maintenance is limited to \$500 annually for the repair and service of items that have been provided through an HCBS waiver:

- Requests for service must detail parts and labor costs.

Section 7: Service Definitions

- If the need for maintenance exceeds \$500, the case manager works with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, parts and labor costs funded through the waiver must be itemized clearly to differentiate waiver service from parts and labor provided through a non-waiver funding source.

Activities Not Allowed

The following items and equipment are not allowed under specialized medical equipment and supplies:

- Hospital beds
- Air fluidized suspension mattresses and beds
- Therapy mats
- Parallel bars
- Scales
- Activity streamers
- Paraffin machines or baths
- Therapy balls
- Books
- Games
- Toys
- Electronics such as CD players, radios, cassette players, tape recorders, television, VCR/DVDs, cameras or film, videotapes, and other similar items
- Computers and software
- Adaptive switches and buttons
- Exercise equipment, such as treadmills or exercise bikes
- Furniture
- Appliances such as refrigerator, stove, hot-water heater
- Indoor and outdoor play equipment, such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, playhouses, merry-go-rounds
- Swimming pools, spas, hot tubs, or portable whirlpool pumps
- Tempur-Pedic-type mattresses, positioning devices, pillows
- Bathtub lifts
- Motorized scooters
- Barrier creams, lotions, or personal cleaning cloths
- Totally enclosed cribs and barred enclosures for restraint purposes
- Vehicle modifications
- Any equipment or items that can be authorized through the Medicaid State Plan
 - Any equipment or items purchased or obtained by the individual, his or her family members, or other non-waiver providers

Provider Qualifications

Table 7.18 – Provider Qualifications Table for Specialized Medical Equipment and Supplies

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	Licensed Home Health Agency	<i>IC 16-27-1</i>	DA approved 455 IAC 2 Warranty required
A&D, TBI	FSSA/DA- Approved Specialized Medical Equipment and Supplies Agency	<i>IC 25-26-21 Certification IC 6-2.5-8-1</i>	DA approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider qualifications: general requirements 455 IAC 2 Maintenance of records of services provided 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements; documentation of qualifications 455 IAC 2 Warranty required

Structured Day Program

Service Definition

Assistance with acquisition; retention; or improvement in self-help, socialization, and adaptive skills that takes place in a nonresidential setting, separate from the home in which the individual resides. Services shall normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in an individual's service plan.

Service Standards

- Structured day program services must follow a written service plan addressing specific needs determined by the individual's assessment.
- Structured day services shall focus on enabling the individual to attain or maintain his or her functional level.
- Structured day program services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Documentation Standards

- Identified need in the service plan
- Services outlined in the service plan
- Data record of services provided, including:
 - Complete date and time of service (in and out)
 - Specific services/tasks provided
 - Signature of the employee providing the service (minimally the last name and first initial). If the person providing the service is required to be a professional, the title of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.

Limitations

Note: Services provided through structured day program should not duplicate any service provided under the Medicaid State Plan or other waiver service.

Provider Qualifications

Table 7.19 – Provider Qualifications Table for Structured Day Program

Waiver	Provider	Licensure/ Certification	Other Standard
TBI	FSSA/DA- Approved Structured Day Program Agency	Not required	<p>DA approved 455 IAC 2 Provider Qualifications; General requirements 455 IAC 2 General requirements for direct care staff 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements 455 IAC 2 Personnel Records</p> <p>Habilitation services must be performed by persons who are supervised by a CBIS or Qualified Intellectual Disability Professional or a physical, occupational, or speech therapist licensed by the state of Indiana and have successfully completed training or have experience in conducting habilitation programs.</p>

Structured Family Caregiving

Service Definition

Structured family caregiving (SFC) means a living arrangement in which a participant lives in their private home or the private home of a principal caregiver who may be a nonfamily member or a family member who is not the participant's spouse, the parent of the participant who is a minor, or the legal guardian of the participant.

Necessary support services are provided by the principal caregiver (family caregiver) as part of structured family caregiving. Only agencies may be structured family caregiving providers, with the structured family caregiving settings being approved, supervised, trained, and paid by the approved agency provider. The provider agency must conduct two visits per month to the home – one by a registered nurse and one by a structured family caregiving home manager. The provider agency must keep electronic daily notes.

The goal of this service is to provide necessary care while emphasizing the participant's independence. The goal is reached through a cooperative relationship between the participant (or the participant's legal guardian), the participant's HCBS Medicaid waiver case manager, and the structured family caregiving provider. The participant's needs shall be addressed in a manner that supports and enables the individual to maximize abilities function at the highest level of independence possible. The service is designed to provide options for alternative long-term care to persons who meet nursing facility level of care and whose needs can be met in a SFC setting.

Another goal is to preserve the dignity, self-respect, and privacy of the participant by ensuring high-quality care in a noninstitutional setting. Care is to be furnished in a way that fosters the independence of each participant to facilitate aging in place in a home environment that provides the participant with a range of care options as the needs of the participant change.

Allowable Activities

- Personal care and services.
- Homemaker or chore services.
- Attendant care and companion care services.
- Medication oversight (to the extent permitted under State law).
- Transportation for community activities that are therapeutic in nature or assist with maintaining natural supports. (Medicaid State Plan transportation should be requested for medical transportation.)
- Respite for the family caregiver. (Funding for this respite is included in the per diem paid to the service provider; the actual service of respite care may not be billed in addition to the *per diem*.)
- Assistance with correspondence and bill paying, if requested by the participant.
- Other appropriate supports, as described in the individual's service plan.

Service Standards

- Structured family caregiving must be reflected in the participant's service plan
- Services must address the participant's level of service needs

Documentation Standards

- Identified need in the service plan

- Services outlined in the service plan
- Requires completed *Adult Family Care Level of Service Evaluation* form. (The case manager must give the completed *Adult Family Care Level of Service Evaluation* form to the provider.)

Activities Not Allowed

- Structured family caregiving service will not be reimbursed when provided as an individual provider by a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the healthcare representative (HCR) of a participant, or the legal guardian of a participant.
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed nurse, or other health professional.
- Separate payment will not be made for homemaker, respite, transportation, personal emergency response system, attendant care, assisted living, home-delivered meals, healthcare coordination, or adult family care, as these activities are integral to and inherent in the provision of structured family caregiving services.

Provider Qualifications

Table 7.20 – Provider Qualifications Table for Structured Family Caregiving

Waiver	Provider	Licensure/ Certification	Other Standard
A&D	FSSA/DA- Approved Structured Family Caregiving Agency	Not required	<p>Provider and home must meet the requirements of the Indiana Adult Foster Care Service Provision and Certification Standards.</p> <p>DA approved</p> <p>455 IAC 2 Becoming an approved provider; maintaining approval</p> <p>455 IAC 2 Provider qualifications: general requirements</p> <p>455 IAC 2 General requirements for direct care staff</p> <p>455 IAC 2 Procedures for protecting individuals</p> <p>455 IAC 2 Unusual occurrence; reporting</p> <p>455 IAC 2 Transfer of individual's record upon change of provider</p> <p>455 IAC 2 Notice of termination of services</p> <p>455 IAC 2 Provider organizational chart</p> <p>455 IAC 2 Collaboration and quality control</p> <p>455 IAC 2 Data collection and reporting standards</p> <p>455 IAC 2 Quality assurance and quality improvement system</p> <p>455 IAC 2 Financial information</p> <p>455 IAC 2 Liability insurance</p> <p>455 IAC 2 Transportation of an individual</p> <p>455 IAC 2 Documentation of qualifications</p> <p>455 IAC 2 Maintenance of personnel records</p> <p>455 IAC 2 Adoption of personnel policies</p> <p>455 IAC 2 Operations manual</p> <p>455 IAC 2 Maintenance of records of services provided</p> <p>455 IAC 2 Individual's personal file; site of service delivery</p>

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Supported Employment

Service Definition

Supported employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly worksites where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

Service Standards

- Supported Employment services must follow a written service plan addressing specific needs determined by the individual's assessment.
- When Supported Employment services are provided at a worksite where persons without disabilities are employed, payment will only be made for the adaptation, supervision and training required by individuals receiving waiver services as a result of their disabilities and will not include payment for supervisory activities rendered as a normal part of the business setting.
- Supported Employment services furnished under the waiver must be services which are not available under a program funded by either the *Rehabilitation Act of 1973* or *P.L. 94-142*. Documentation will be maintained in the file of each individual receiving this service, showing that the service is not otherwise available under a program funded under the *Rehabilitation Act of 1973* or *P.L. 94-142*.

Documentation Standards

- Identified need in the service plan.
- Services outlined in the service plan.
- Data record of services provided, including:
 - Complete date and time of service (in and out).
 - Specific services /tasks provided.
 - Signature of employee providing the service (minimally the last name and first initial). If the person providing the service is required to be a professional, the title of the individual must also be included.
- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.

Limitations

When supported employment services are provided at a worksite where persons without disabilities are employed, payment will only be made for the adaptation, supervision, and training required by individuals receiving waiver services as a result of their disabilities.

Activities Not Allowed

- Services funded under the Rehabilitation Act of 1973 or P.L. 94-142
- Reimbursement for supervisory activities rendered as a normal part of standard business procedures in a business setting where persons without disabilities are also employed

Section 7: Service Definitions

- Reimbursement for incentive payments, subsidies, or unrelated vocational training expenses for the following:
 - Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program
 - Payments that are passed through to users of supported employment programs or
 - Payments for vocational training that are not directly related to an individual's employment program

Provider Qualifications

Table 7.21 – Provider Qualifications Table for Supported Employment

Waiver	Provider	Licensure/ Certification	Other Standard
TBI	FSSA/DA- Approved Supported Employment Agency	Certification CARF	DA approved 455 IAC 2 Provider qualifications; general requirements 455 IAC 2 General requirements for direct care staff 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements 455 IAC 2 Personnel records
TBI	Community Mental Health Center	Not required	DA approved 455 IAC 2 Provider qualifications; general requirements 455 IAC 2 General requirements for direct care staff 455 IAC 2 Liability insurance 455 IAC 2 Professional qualifications and requirements 455 IAC 2 Personnel records IC 12-7-2-38(1) Community Mental Health Center

Transportation

Service Definition

Transportation services are services offered in order to enable individuals served under the waiver to gain access to waiver and other community services, activities, and resources, specified by the service plan.

Service Standards

- Transportation services must follow a written service plan addressing specific needs determined by the individual's assessment.
- This service is offered in addition to medical transportation required under *42 CFR 431.53* and transportation services under the Medicaid State Plan, defined at *42 CFR 440.170(a)* (if applicable), and should not replace them.
- Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Transportation services are reimbursed at three types of service:

- Level 1 transportation – The individual does not require mechanical assistance to transfer in and out of the vehicle.
- Level 2 transportation – The individual requires mechanical assistance to transfer into and out of the vehicle.
- Adult day service transportation – The individual requires round-trip transportation to access adult day services.

Documentation Standards

- Identified need in the service plan.
- Services outlined in the service plan.
- A provider or its agent shall maintain documentation that the provider meets and maintains the requirements for providing services under *460 IAC 1.2*.

Limitations

Services provided under transportation service will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Activities Not Allowed

- May not be used to meet medical transportation needs already available under the Medicaid State Plan.
- Separate waiver transportation services are not available to participants receiving adult family care services.
- Services to participants receiving assisted living waiver service.

Provider Qualifications

Table 7.22 – Provider Qualifications Table for Transportation

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	Licensed Home Health Agency	IC 16-27-1	DA approved Compliance with applicable vehicle/driver licensure for vehicle being utilized
A&D, TBI	FSSA/DA- Approved Transportation Agency	Not required	DA approved 455 IAC 2 Becoming an approved provider; maintaining approval 455 IAC 2 Provider qualifications: general requirements 455 IAC 2 General requirements for direct care staff 455 IAC 2 Procedures for protecting individuals 455 IAC 2 Unusual occurrence; reporting 455 IAC 2 Transfer of individual's record upon change of provider 455 IAC 2 Notice of termination of services 455 IAC 2 Provider organizational chart 455 IAC 2 Collaboration and quality control 455 IAC 2 Data collection and reporting standards 455 IAC 2 Quality assurance and quality improvement system 455 IAC 2 Financial information 455 IAC 2 Liability insurance 455 IAC 2 Transportation of an individual 455 IAC 2 Documentation of qualifications 455 IAC 2 Maintenance of personnel records 455 IAC 2 Adoption of personnel policies 455 IAC 2 Operations manual 455 IAC 2 Maintenance of records of services provided 455 IAC 2 Individual's personal file; site of service delivery Compliance with applicable vehicle/driver licensure for vehicle being utilized

Vehicle Modifications

Service Definition

Vehicle modifications (VMOD) are the addition of adaptive equipment or structural changes to a motor vehicle that permit an individual with a disability to safely transport in a motor vehicle. Vehicle modifications, as specified in the service plan, may be authorized when necessary to increase an individual's ability to function in a home and community based setting and to ensure accessibility of the individual with mobility impairments. These services must be necessary to prevent or delay institutionalization. The necessity of such items must be documented in the service plan by a physician's order. Vehicles necessary for an individual to attend post-secondary education or job related services should be referred to Vocational Rehabilitation Services.

The vehicle to be modified must meet all the following:

- The individual or primary caregiver is the titled owner.
- The vehicle is registered and/or licensed under state law.
- The vehicle has appropriate insurance as required by state law.
- The vehicle is the individual's sole or primary means of transportation.
- The vehicle is not registered to or titled by a FSSA approved provider.

All vehicle modifications must be approved by the waiver program prior to services being rendered.

- Vehicle modification requests must meet and abide by the following:
 - The vehicle modification is based on, and designed to meet, the individual's specific needs.
 - Only one vehicle per an individual's household may be modified.
 - The vehicle is less than 10 years old and has less than 100,000 miles on the odometer.
 - If the vehicle is more than five years old, the individual must provide a signed statement from a qualified mechanic verifying that the vehicle is in sound condition.
- All vehicle modification shall be authorized only when it is determined to be medically necessary and/or shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:
 - The modification is the most cost effective or conservative means to meet the individual's specific needs.
 - The modification is individualized, specific, and consistent with, but not in excess of, the individual's needs.
 - All bids must be itemized.
- Many automobile manufacturers offer a rebate of up to \$1,000 for individuals purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate, the individual is required to submit to the manufacturer documented expenditures of modifications. If the rebate is available, it must be applied to the cost of the modifications.
- Requests for modifications may be denied if the DA director or designee determines the documentation does not support the service requested.

Allowable Activities

Justification and documentation is required to demonstrate that the modification is necessary in order to meet the individual's identified needs. The following are allowed under vehicle modifications:

- Wheelchair lifts;

Section 7: Service Definitions

- Wheelchair tie-downs (if not included with lift);
- Wheelchair/scooter hoist;
- Wheelchair/scooter carrier for roof or back of vehicle;
- Raised roof and raised door openings;
- Power transfer seat base (excludes mobility base);
- Maintenance is limited to \$500 annually for repair and service of items that have been funded through an HCBS waiver:
 - Requests for service must differentiate between parts and labor costs.
 - If the need for maintenance exceeds \$500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.
- Items requested that are not previously listed must be reviewed and decision rendered by the State division director or State agency designee.

Service Standards

- Vehicle modification must be of direct medical or remedial benefit to the individual
- All items must meet applicable manufacturer, design, and service standards

Documentation Standards

- The identified direct benefit or need must be documented within:
 - Service plan
 - Physician prescription and/or clinical evaluation as deemed appropriate
- Documentation/explanation of service within the RFA to authorize services must include:
 - Ownership of vehicle to be modified
 - Vehicle owner's relationship to the individual
 - Make, model, mileage, and year of vehicle to be modified
- Signed and approved RFA
- Signed and approved service plan
- Provider of services must maintain receipts for all incurred expenses related to the modification
- Must be in compliance with FSSA- and division-specific guidelines and/or policies

Limitations

A lifetime cap of \$15,000 is available for vehicle modifications. In addition to the applicable lifetime cap, \$5,000 will be allowable annually for repair, replacement, or an adjustment to an existing modification that was funded by an HCBS waiver.

Activities Not Allowed

Examples or descriptions of modifications/items not covered include, but are not limited to, the following:

- Lowered-floor van conversions
- Purchase, installation, or maintenance of CB radios, cellular phones, global positioning and tracking devices, or other mobile communication devices
- Repair or replacement of modified equipment damaged or destroyed in an accident

- Alarm systems
- Auto loan payments
- Insurance coverage
- Driver's license, title registration, or license plates
- Emergency road service
- Routine maintenance and repairs related to the vehicle itself
- Services to participants receiving adult family care waiver service
- Services to participants receiving assisted living waiver service

Provider Qualifications

Table 7.23 – Provider Qualifications Table for Vehicle Modifications

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	FSSA/DA approved Vehicle Modification Agency	Not required	DA approval based upon provider compliance with <i>455 IAC 2</i> DA approved <i>455 IAC 2</i> Becoming an approved provider; maintaining approval <i>455 IAC 2</i> Provider qualifications: general requirements <i>455 IAC 2</i> Liability insurance <i>455 IAC 2</i> Professional qualifications and requirements; documentation of qualifications <i>455 IAC 2</i> Maintenance of records of services provided <i>455 IAC 2</i> Warranty required

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Section 8: Provider Help

INsite Communication Instructions

The following are the steps for the case manager to obtain communications from INsite:

1. From the main screen in INsite, click **Release Notes**.
2. Click **Manuals > Bulletins > Procedures**.
3. Choose the manual to view, look at the entire table of contents (double-click on the manual title), index, or perform a search.
4. Contact the INsite Helpdesk at Insite.helpdesk@fssa.in.gov if additional assistance is needed.

Helpful Websites

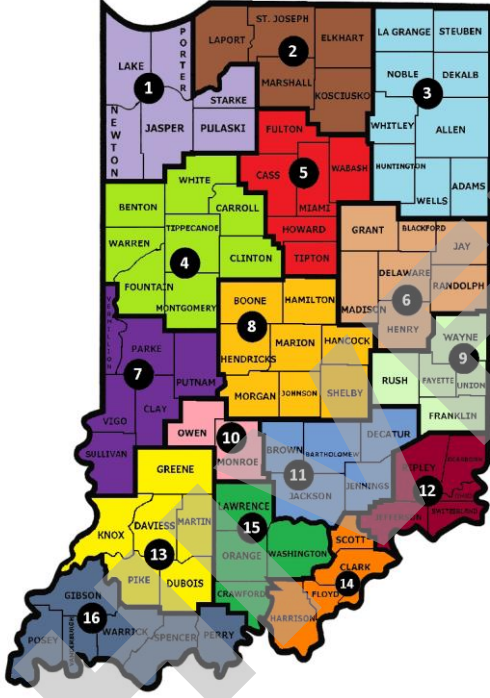
Consult the following websites for more information:

- www.in.gov/fssa – Find information by type of person in need: children, seniors, families, developmentally disabled (DD), and so forth. All programs and services available are listed on this site.
- www.in.gov/fssa/2329.htm – Find information and resources about the Division of Aging (DA) programs and services.
- www.in.gov/fssa/da/4743.htm – Find information about how to become a provider of DA services.
- <https://ddrsprovider.fssa.in.gov/IFUR> – Submit initial incident reports and case manager follow-up reports for waiver and Money Follows the Person (MFP) services.
- www.indianamedicaid.com – Find IHCP provider bulletins and the *IHCP Provider Manual*. Telephone contact information for providers is also available on this website.

Helpful Contact Numbers

Contact the Division of Aging at 1-888-673-0002. See Figure 8.1 for information on local Area Agency on Aging offices.

Figure 8.1: Location and contact information for local AAA offices

<p>AREA 1 Northwest Indiana Community Action Corporation 5240 Fountain Drive Crown Point, IN 46307 219.794.1829 OR 800.826.7871 TTY: 888.814.7597 FAX: 219.794.1860 www.nwi-ca.com</p> <p>AREA 2 REAL Services, Inc. 1151 S. Michigan Street South Bend, IN 46601-3427 574.284.2644 OR 800.552.7928 FAX: 574.284.2642 www.realservicesinc.org</p> <p>AREA 3 Aging & In-Home Services of Northeast Indiana, Inc. 2927 Lake Avenue Fort Wayne, IN 46805-5414 260.745.1200 OR 800.552.3662 FAX: 260.422.4916 www.agingihs.org</p> <p>AREA 4 Area IV Agency on Aging & Community Action Programs, Inc. 660 N. 36th Street Lafayette, IN 47903-4727 765.447.7683 OR 800.382.7556 TDD: 765.447.3307 FAX: 765.447.6862 www.areaivagency.org</p> <p>AREA 5 Area Five Agency on Aging & Community Services, Inc. 1801 Smith Street, Suite 300 Logansport, IN 46947-1577 574.722.4451 OR 800.654.9421 FAX: 574.722.3447 www.areafive.com</p> <p>AREA 6 LifeStream Services, Inc. 1701 Pilgrim Boulevard Yorktown, IN 47396-0308 765.759.1121 OR 800.589.1121 TDD: 800.801.6606 FAX: 765.759.0060 www.lifestreaminc.org</p> <p>AREA 7 Area 7 Agency on Aging and Disabled West Central Indiana Economic Development District, Inc. 1718 Wabash Avenue Terre Haute, IN 47807 812.238.1561 OR 800.489.1561 TDD: 800.489.1561 FAX: 812.238.1564 www.westcentralin.com</p>	<p style="text-align: center;">16 Area Agencies</p>  <p>AREA 8 CICOA Aging & In-Home Solutions 4755 Kingsway Drive, Suite 200 Indianapolis, IN 46205-1560 317.254.5465 OR 800.432.2422 TDD: 317.254.5497 FAX: 317.254.5494 www.cicoa.org</p> <p>AREA 9 Area 9 In-Home & Community Service Agency 520 South 9th Street Richmond, IN 47374 765.966.1795 OR 800.458.9345 FAX: 765.962.1190 www.iue.edu/area9</p> <p>AREA 10 Area 10 Agency on Aging 631 W. Edgewood Drive Ellettsville, IN 47429 812.876.3383 OR 800.844.1010 FAX: 812.876.9922 www.area10agency.org</p>	<p>AREA 11 Thrive Alliance 1531 13th Street, Suite G900 Columbus, IN 47201 812.372.6918 OR 866.644.6407 FAX: 812.372.7864 www.thrive-alliance.org</p> <p>AREA 12 LifeTime Resources, Inc. 13091 Benedict Drive Dillsboro, IN 47018 812.432.6200 OR 800.742.5001 FAX: 812.432.3822 www.lifetime-resources.org</p> <p>AREA 13 Generations Vincennes University Statewide Services 1019 N. 4th Street Vincennes, IN 47591 812.888.5880 OR 800.742.9002 FAX: 812.888.4566 www.generationsnetwork.org</p> <p>AREA 14 LifeSpan Resources, Inc. 33 State Street, Third Floor New Albany, IN 47151-0995 812.948.8330 OR 888.948.8330 TTY: 812.542.6895 FAX: 812.948.0147 www.lsr14.org</p> <p>AREA 15 Hoosier Uplands / Area 15 Agency on Aging and Disability Services 521 West Main Street Mitchell, IN 47446 812.849.4457 OR 800.333.2451 TDD: 800.743.3333 FAX: 812.849.4467 www.hoosieruplands.org</p> <p>AREA 16 SWIRCA & More 16 W. Virginia Street Evansville, IN 47737-3938 812.464.7800 OR 800.253.2188 FAX: 812.464.7843 www.swirca.org</p>
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To contact your local Area Agency toll-free, call **1-800-986-3505**.

Communications

General Information

The Indiana Health Coverage Programs (IHCP) publishes the following communications to providers at indianamedicaid.com:

- IHCP provider bulletins
- IHCP banner pages (published each week)

Providers may also subscribe to the [Email Notification Service](#) at indianamedicaid.com. This service sends emails to subscribers when new communications are posted on indianamedicaid.com.

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Index

A

address and telephone changes..... 1-2
adult day services 7-1
adult family care..... 7-4
Aged and Disabled waiver 5-1
Area Agencies on Aging 5-1, 8-2
assisted living 7-8
attendant care 7-10

B

banner pages 8-3
behavior management 7-13
bulletins 8-3

C

case management 6-1, 7-15
certification 1-3
claim voids and replacements 2-2
claims billing instructions 2-1
community transition 7-19

D

dietary supplements.....See nutritional supplements

E

eligibility 2-1
E-mail Notification Service 8-3
environmental modification assessment .. 7-26
environmental modifications 7-21

H

healthcare coordination 7-28
Home and Community-Based Services waivers 1-1
home-delivered meals..... 7-30
homemaker services 7-32

I

IndianaAIM 1-2
INsite 1-2, 2-1, 8-1

L

level of care 1-2, 5-1
LOC See level of care

M

Medicaid Fraud Control Unit..... 4-1
Medicaid Management Information System 1-2
MFCU..... See Medical Fraud Control Unit
MMIS See Medicaid Management Information System

N

NOA..... See Notice of Action
Notice of Action 1-2
nutritional supplements..... 7-34

P

personal emergency response system..... 7-36
pest control services 7-38
provider application process..... 1-3
provider database 1-2
Provider Enrollment Application 1-4
Provider Enrollment Update Form 1-5
provider enrollment updates 1-5
Provider Licensure and Certification
Adult Day Service 7-3
Adult Family Care 7-6, 7-51
Assisted Living 7-9
Attendant Care..... 7-11
Behavior Management/Behavior Program and Counseling..... 7-14
Case Management 7-16
Community Transition..... 7-20
Environmental Modification Assessor .. 7-27
Environmental Modifications..... 7-25
Health Care Coordination..... 7-29
Home Delivered Meals..... 7-31
Homemaker Services 7-33
Nutritional Supplements 7-34
Personal Emergency Response System. 7-37
Pest Control..... 7-39
Residential Based Habilitation 7-41
Respite 7-43
Specialized Medical Equipment and Supplies 7-47
Structured Day Program 7-49
Supported Employment 7-54
Transportation 7-56
Vehicle Modifications..... 7-59
provider selection profiles 1-2

R

residential-based habilitation	7-40
respite services.....	7-42

S

Section 1915(c) of the Social Security Act ...	1-1
specialized medical equipment and supplies	7-44
structured family caregiving.....	7-50
supported employment.....	7-53

T

telephone and address changes	1-2
transportation services	7-55
Traumatic Brain Injury waiver	5-2

V

vehicle modifications	7-57
-----------------------------	------

W

waiver audits.....	4-1
--------------------	-----