



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Division of Aging

Home and

Community-Based

Services Waivers

LIBRARY REFERENCE NUMBER: PRPR10013
PUBLISHED: AUGUST 8, 2017
POLICIES AND PROCEDURES AS OF APRIL 1, 2017
CoreMMIS UPDATES AS OF FEBRUARY 13, 2017
VERSION: 5.0

Revision History

Version	Date	Reason for Revision	Completed By
1.0	Policies and Procedures as of January 1, 2013 Published: June 10, 2013	Initial release	FSSA
1.1	Policies and Procedures as of November 1, 2013 Published December 19, 2013	Semiannual review	FSSA and DXC Waiver Analyst
2.0	Policies and Procedures as of May 1, 2014 Published August 5, 2014	Semiannual review	FSSA and DXC Waiver Analyst
2.1	Policies and Procedures as of November 1, 2014 Published January 8, 2015	Semiannual review	FSSA and DXC Waiver Analyst
3.0	Policies and Procedures as of May 1, 2015 Published July 16, 2015	Semiannual review	FSSA and DXC Waiver Analyst
3.1	Policies and Procedures as of October 1, 2015 Published February 25, 2016	Update to modular style, semiannual review	FSSA and DXC
4.0	Policies and Procedures as of April 1, 2016 Published June 28, 2016	Semiannual review	FSSA and DXC
4.1	Policies and procedures as of April 1, 2016 <i>CoreMMIS</i> updates as of February 13, 2017 Published: March 23, 2017	<i>CoreMMIS</i> updates	FSSA and DXC
5.0	Policies and procedures as of April 1, 2017 <i>CoreMMIS</i> updates as of February 13, 2017 Published: August 8, 2017 <ul style="list-style-type: none"> • Statewide Transition Plan • CMS 1500 updates • Third Party Liability • OGC exclusionary list 	Semiannual review	FSSA and DXC

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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 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](#)

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

Indiana Health Coverage Programs Waiver Provider Responsibilities

Complete information on provider enrollment, eligibility, and responsibilities is available in the [Provider Enrollment](#) provider reference module at indianamedicaid.com.

IHCP Provider Agreement

Medicaid-enrolled HCBS 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. The *IHCP Provider Agreement* is included in the enrollment application; see the HCBS [Waiver Provider Enrollment](#) section of this module for details. By signing the agreement, the provider agrees to follow the information provided in the *IHCP Provider Reference Modules*, as amended periodically, including the *Division of Aging Home and Community-Based Services Waivers* module, as amended periodically, as well as all provider bulletins, banners, and notices. All amendments to the *IHCP Provider Reference Modules*, including the *Division of Aging Home and Community-Based Services Waivers* module, and all applicable Indiana Administrative Codes (IACs), Rules, and Regulations are binding on publication. The *Division of Aging Home and Community-Based Services Waivers* module and all publications are available online on the [Provider Reference Materials](#) page at indianamedicaid.com.

The information is made available to assist all those who administer, manage, and participate in the A&D and TBI waiver programs. The information and direction in this module replaces all previous HCBS waiver documents. Current HCBS waiver requirements can be found in the CMS approved applications and the *Aging Rule, 455 IAC 2*.

Office of Inspector General Exclusionary List

The U.S. Health and Human Services Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all federal healthcare programs (as defined in [Section 1128B\(f\)](#) of the *Social Security Act* – the Act). When the HHS-OIG has excluded a provider, federal healthcare programs, including Medicaid and SCHIP programs, are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities (*Section 1903(i)(2)* of the Act; and *42 CFR section 1001.1901(b)*). This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity. The prohibition applies to payments for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services knew or should have known of the exclusion even when the payment itself is made to another provider, practitioner, or supplier that is not excluded.

HHS-OIG maintains the [List of Excluded Individuals and Entities \(LEIE\)](#), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other federal healthcare programs. The LEIE data base is available online or may be downloaded. The [online](#) search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the online format, the downloadable database does not contain SSNs or EINs.

IHCP Provider obligations

All current IHCP providers and providers applying to participate in the IHCP program are required to take the actions outlined below to determine whether their employees and contractors are excluded individuals or entities. Providers are required to agree to comply with these obligations as a condition of enrollment.

- Screen all employees and contractors to determine whether any of them have been excluded. Providers can access the LEIE database on the HHS-OIG website at oig.hhs.gov and search by the names of any individual or entity.
- Search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search.
- Report to the State any exclusion information discovered by contacting the Provider and Member Concern Line toll free at 1-800-457-4515.

Because it is prohibited by federal law, no payments can be made for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) by an individual or entity while being excluded from participation (unless the claim for payment meets an exception listed in *42 CFR section 1001.1901(c)*). Any such payments actually claimed for federal financial participation constitute an overpayment, and are therefore subject to recoupment. The amount of the Medicaid overpayment for such items or services is the actual amount of Medicaid dollars that were expended for those items or services. When Medicaid funds have been expended to pay an excluded individual's salary, expenses, or fringe benefits, the amount of the overpayment is the amount of those expended Medicaid funds. Civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients.

The listing below provides some examples of types of items or services that, when provided by excluded parties, are not reimbursable and would constitute an overpayment subject to recoupment.

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays, or review of treatment plans if such services are

reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid member;

- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by excluded ambulance drivers, dispatchers, and other employees involved in providing transportation reimbursed by a Medicaid program, to hospital patients or nursing home residents;
- Services performed for program recipients by excluded individuals who sell, deliver, or refill orders for medical devices or equipment being reimbursed by a Medicaid program;
- Services performed by excluded social workers who are employed by healthcare entities to provide services to Medicaid members, and whose services are reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by an excluded administrator, billing agent, accountant, claims processor, or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid program;
- Items or services provided to a Medicaid member by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of members, and reimbursed, directly or indirectly, by a Medicaid program.

Provider Record Updates

To ensure timely communication of all information, providers must notify the FSSA's Division of Aging and IHCP when enrollment record information changes. Provider information is stored in several FSSA systems: Core Medicaid Management Information System (*CoreMMIS*), the Provider Healthcare Portal, and INsite. *CoreMMIS* is maintained by DXC Technology (DXC), the FSSA's fiscal agent, and the IHCP. INsite is maintained by the FSSA's Division of Aging for all DA waiver providers.

The fiscal agent is responsible for maintaining *CoreMMIS*; 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 IHCP within 10 business 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. Provider profile maintenance forms are available at the [Update Your Provider Profile](#) page at indianamedicaid.com, or updates can be made via the [Provider Healthcare Portal](#).

INsite is the system that stores member eligibility information along with the member's service plans, Notice of Actions (NOAs), level of care (LOC) information, and case notes entered by the case managers for individual members. INsite also has a provider database that is maintained by DA 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 IHCP waiver/provider analyst 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 member change, the provider must contact the case manager to discuss revising the service plan.

Pursuant to the signed provider agreement, all direct care providers must submit a criminal background check as required by *455 IAC 2*. The criminal background check must not show any evidence of acts, offenses, or crimes affecting the applicant's character or fitness to care for waiver consumers in their homes or other locations. Additionally, licensed professionals are checked for findings through the Indiana Professional Licensing Agency. The DA also requires that a current limited criminal history be obtained from the Indiana State Police central repository as prescribed in *455 IAC 2, Adoption of Personnel Policies*, for each employee or agent involved in the direct management, administration, or provision of services in order to qualify to provide direct care to members receiving services at the time of provider certification. Direct care staff is also checked against the nurse aide registry at the Indiana Professional Licensing Agency to verify that each unlicensed employee or agent involved in the direct provision of services has no finding entered into the registry in order to qualify to provide direct care to members receiving services. The DA Provider Relations waiver specialist verifies receipt of documentation as a part of provider enrollment.

Criminal history checks are maintained in agency files and are available upon request.

The Indiana Professional Licensing Agency is responsible for maintaining the nurse aide registry. Pursuant to *Indiana Administrative Code 455 IAC 2, General Requirements*, the provider must obtain and submit a current document from the nurse aide registry of the Indiana Professional Licensing Agency, verifying that each unlicensed employee involved in the direct provision of services has no finding entered into the registry before providing direct care to members receiving services. The DA Provider Relations waiver specialist verifies receipt of documentation as part of provider enrollment.

Nurse aide registry documents are maintained in agency files and are available upon request. Providers are required to furnish at least 30 calendar days' written notice before terminating waiver services to a member. This notice must be made to the member, the legal representative, if applicable, the member's case manager, and the DA.

For more provider specific information, please visit the Division of Aging's Provider information page located at fssa.in.gov

IHCP implemented a CMS mandate to require federal criminal background checks for owners of entities assigned to the high risk category who have enrolled since 8-1-15.

For DA's waiver providers, this will include providers of:

- Attendant care Services
- And
- Specialized medical equipment and supplies

Waiver Provider Application and Certification

Becoming a waiver provider begins with the FSSA's /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 agent, DXC. 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: **MS 21**
ATTN: Waiver/Provider Analyst
Family and Social Services Administration
Indiana Health Coverage Programs (IHCP)
DA Home and Community-Based Services
402 West Washington Street, Room W454
P.O. Box 7083
Indianapolis, Indiana 46204-7083

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 DA staff.
- If additional information is needed, applicants may be contacted via email or telephone with a request for additional information. A 30-calendar 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, DXC Technology (DXC), 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 IHCP billing number
 - Are activated in the waiver provider database
 - Receive a 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 calendar days of certification.**

- Prospective providers may enroll online through the [Provider Healthcare Portal](http://portal.indianamedicaid.com) available at portal.indianamedicaid.com. Click the Provider Enrollment link to begin the enrollment process. For instructions on how to enroll via the Portal, see the *Provider Enrollment* provider module at indianamedicaid.com.
- To enroll by mail, a prospective provider may obtain an IHCP Provider Enrollment Packet by downloading it from the [Complete an IHCP Provider Packet](#) page at indianamedicaid.com, or by contacting 1-800-457-4584 (Option 2) 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 DXC at the following address:

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

Helpful Tips for Completing the IHCP Enrollment Application

The application asks the provider to choose a business structure. An HCBS Waiver provider is enrolled as either 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 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 those it is certified by the DA to provide, and the DA certifies services for the following:

- 350 – Aged & Disabled Waiver (A&D)
- 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 *HCBS Waiver Service Certification Letter*. Enrollments submitted via the Portal, allow electronic signatures and electronic attachments.)

All paper enrollment forms must be directed to the IHCP 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 an application tracking number (ATN).

The IHCP Provider Enrollment Unit has dedicated staff members assigned to coordinate and handle all HCBS waiver provider enrollments and updates. These staff members work closely with the DA to ensure timely and accurate maintenance of HCBS waiver provider enrollment processes.

The IHCP staff members review the IHCP provider enrollment packet to ensure completeness according to the Provider Enrollment guidelines. If the information is completed accurately and approved, the IHCP Provider Enrollment team then enters the provider’s information into *CoreMMIS*. For enrollment applications submitted via the Provider Healthcare Portal, the provider’s information transfers automatically into *CoreMMIS*. A provider letter is generated from the IHCP notifying the provider agency that it is now a Medicaid-enrolled HCBS waiver provider. This letter is sent to the provider detailing the assigned IHCP provider billing number and enrollment information entered into *CoreMMIS*. Providers are encouraged to review this letter to ensure enrollment accuracy.

If a provider enrollment packet needs correcting or is missing required documentation, the IHCP 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. If an application is rejected for missing or incomplete information, the entire packet will be returned to the applicant with a letter indicating what needs to be corrected or attached. The applicant **MUST** return the entire packet, as well as a copy of the provider letter, when submitting the correction or missing information.

DA Waiver Provider Information Updates

Updates to the following information must be submitted within 10 calendar 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's DA)
 - 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 DA sends a new *Waiver Service Certification Letter* to the provider detailing the approved services and instructing the provider to begin the update process with the IHCP. The IHCP Provider Enrollment staff member works closely with the DA to complete and maintain provider enrollment information.

Providers can update their information using the Provider Healthcare Portal or by mail using the appropriate enrollment packet or profile maintenance form, available from the [Update Your Provider Profile](#) page at indianamedicaid.com or by contacting IHCP Customer Assistance at 1-800-457-4584 (Option 2). Providers must complete the update form with appropriate signature and submit the form along with the waiver certification letter to DXC at the following address:

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

Section 2: Claims and Billing

Overview

The Family and Social Services Agency (FSSA) is the Single State Medicaid Agency. The Division of Aging (DA), a division under the FSSA, has been given the authority to administer the Aged and Disabled (A&D) and Traumatic Brain Injury (TBI) Waivers. The Office of Medicaid Policy and Planning (OMPP), also a division under the FSSA, has been given the administrative authority for the A&D and TBI waivers by the FSSA. The DA performs the daily operational tasks of the waiver.

Eligibility for HCBS Waiver Services Affects Billing

All potential Home and Community-Based Services (HCBS) 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 be enrolled in a fee-for-service Medicaid program and have an open waiver level of care (LOC) status in *CoreMMIS*. 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 A&D and TBI waivers. Initial eligibility (level of care) is determined by the entry point agencies. Before the level of care is recorded in *CoreMMIS*, a member must have fee-for-service Medicaid, 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 *CoreMMIS* by the DA.

If an individual is in a, Hoosier Care Connect, Health Indiana Plan or any other Medicaid managed care program, the case manager must contact the local FSSA/DFR caseworker to coordinate the managed care program stop date and waiver services start date. If applicable, the case manager and managed care benefit advocate must inform the individual and individual's parent or guardian of his or her options to ensure that he or she makes an informed choice.

If a member does not have an active waiver level of care and/or is not currently enrolled in Indiana Medicaid fee-for-service programs on the date on which services were provided, any claim submitted may not be paid.

<p><i>Note: The fiscal agent cannot add or correct a waiver level of care segment in CoreMMIS nor terminate a managed care enrollment.</i></p>
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Waiver Authorization

AAAs, through their qualified case managers, are responsible for preparing a written service plan for each individual member. The service plan must describe the medical and other services, regardless of funding source (that is, medical transportation under PA, skilled respite under waiver, in-home hospice through the Medicaid State Plan prior authorization process) to be furnished, the frequency of each service the member is receiving, and the type of provider (home health provider under Medicaid prior authorization, waiver provider, and family member) who will furnish each service. All services will be furnished pursuant to a written service plan. The service plan is subject to the approval of the DA and/or the OMPP.

Each of the sixteen AAA are responsible for disseminating information regarding the waiver to potential enrollees, assisting individuals in the waiver enrollment application process, conducting level of care evaluation activities, recruiting providers to perform waiver services, and conducting training and technical assistance concerning waiver requirements.

The waiver case manager is responsible for completing the service plan, which, if approved by the DA, results in an approved Notice of Action (NOA). The NOA details the waiver-funded services and number of units for the waiver service to be provided, the name of the authorized waiver 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 CoreMMIS, 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 on the approved NOA.

Billing Instructions

HCBS waiver claims are billed on the paper *CMS-1500* claim form, via the 837P electronic transaction, or through the professional claim submission function on the Provider Healthcare Portal, an interactive web application that allows providers to submit claims and attachments, check eligibility, and check status of claims. The Portal is fast, free, and does not require special software. Paper copies of the *CMS-1500, Version 02/12* form are available from the [U.S. Government Bookstore](#) or other online retailers. In the near future, DXC will no longer accept photocopies of the CMS-1500 form. Providers wishing to bill using the paper copies, must use an original CMS-1500 form. Instructions for completing the form are in the [Home and Community-Based Services Billing Guidelines](#) and [Claim Submission and Processing](#) modules at indianamedicaid.com. Providers must register on the portal to use the Healthcare Portal to submit claims, verify member eligibility, and maintain enrollment data.

Providers bill services based on an approved NOA for the individual member, 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 Indiana Medicaid waiver claims, the provider must consider the following:

- The IHCP does not reimburse HCBS services for time spent by office staff billing claims.
- Providers may bill only for services authorized on an approved NOA that were delivered to the member.

- 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 and be supported by the member's individual person-centered plan of care.
- 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, available on the [Bulletins](#) page at indianamedicaid.com, and DA bulletins (sent via email and posted on the DA agency websites). Each provider is responsible for obtaining the information and implementing new or revised policies and procedures, as outlined in these notices.

The fiscal agent and the FSSA recommend submitting claims electronically. Providers may submit claims electronically using the Provider Healthcare Portal. For information about the Provider Healthcare Portal, see the [Provider Healthcare Portal](#) provider reference module or contact the Electronic Solutions Helpdesk at 1-800-457-4584 (Option 3). For information about how to complete the paper *CMS-1500* claim form, see the [Home and Community-Based Services Billing Guidelines](#) and [Claim Submission and Processing](#) provider reference modules 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 [Claim Submission and Processing](#) provider reference module. For information about performing a void and replacement online, see the [Provider Healthcare Portal](#) provider reference module.

Third-Party Liability Exempt

The IHCP will not bill private insurance carriers through the third-party liability (TPL) or reclamation processes for claims containing any HCBS benefit modifier codes. This billing practice includes modifiers specific to claims for the following benefit plans:

- Aged and Disabled HCBS Waiver (A&D Waiver)
- Traumatic Brain Injury HCBS Waiver (TBI Waiver)

Division of Aging HCBS Waiver Rates

Table 1 identifies procedure codes and modifiers, the waivers for which the service is available, and the payment methodology associated with the procedure code.

Table 1 – Division of Aging HCBS Waiver Rates as of May 1, 2014

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
	Attendant Care Consumer Directed Overtime	S5125	U7	U1	TU	U7=WAIVER U1=ATTC FI TU=OVERTIME	\$1.38	N/A	.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
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

INsite Code	Service	Price Code	Mod 1	Mod 2	Mod 3	Dsc Proc Modified	A&D 127	TB 131	Notes
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
RNUR	Respite Care Services	T1005	U7	UA	TE	U7=WAIVER UA=PROVIDE R, 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=REPLACE MENT 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

INsite Code	Service	Price Code	Mod 1	Mod 2	Mod 3	Dsc Proc Modified	A&D 127	TB 131	Notes
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
	Transportation – Not Assisted	T2004	U7	U1		U7=WAIVER U1=NON-ASSISTED	\$233.00	\$150.00	Monthly
	Transportation – Assisted	T2004	U7	U2		U7=WAIVER U2=ASSISTED	\$452.00	\$300.00	Monthly
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

Section 3: Quality Assurance/Quality Improvement

Quality Monitoring

The Division of Aging (DA) is responsible for the assessment and performance of contracted and/or local/regional nonstate entities in conducting waiver operational functions. The DA also collaborates with the Office of Medicaid Policy and Planning (OMPP) regarding issues concerning contracted and/or local and regional nonstate entities.

The DA monitors the Area Agencies on Aging (AAAs) and non-AAA case management entities through the electronic case management system, monthly communication with AAAs to verify compliance with performance, and on-site follow-up through quality assurance surveys using the Person Centered Compliance Tool (PCCT) and the Provider Compliance Tool (PCT).

As detailed in *455 IAC 2*, 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 DA 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 DA. The role of the DA QA/QI Unit is to:

- Monitor all waiver enrolled providers who are delivering waiver services to enrolled members.
- Assure that services to all members are delivered in accordance with the member's person-centered service plan, the specifications identified in the approved waiver, and *455 IAC 2*.
- Collect and analyze information and data in order to implement sound remediation of problems at the individual, organization, and systemic levels.
- Participate with stakeholders in the development of policies and procedures that all providers, including case managers, must follow to assure compliance with Indiana Administrative Code (IAC) and Centers for Medicare & Medicaid Services (CMS) assurances, and to protect members' health and welfare.

The components of the DA QA/QI program are:

- Incident reporting
- Complaint resolution
- Mortality review
- Coordination with Adult Protective Services (APS), the local AAAs and case managers
- Quality reviews (provider compliance reviews, person-centered compliance reviews, member experience surveys)
- Coordination with Medicaid Surveillance and Utilization Review (SUR) and the Indiana State Department of Health (ISDH)
- Implementation of the Quality Improvement Strategy (QIS) process

Incident Reporting

Indiana's 455 IAC 2 requires all providers of HCBS waiver services, including case managers, to submit incident reports to the DA when specific events occur. The nature of these events is defined as an unusual occurrence affecting the health and safety of an HCBS participant.

Events that must be reported include but are not limited to:

- Alleged, suspected, reported, or observed abuse/battery, neglect, or exploitation of a member
- The unexpected death of a member
- Significant injuries to the member requiring emergent medical intervention
- Any threat or attempt of suicide made by the member
- Any unusual hospitalization due to a significant change in health and/or mental status may require a change in service provision
- Member elopement or missing person
- Inadequate formal or informal support for a member, including inadequate supervision, which endangers the member
- Medication error occurring in a 24/7 or day setting
- A residence that compromises the health and safety of a participant
- Suspected or observed criminal activity by (a) provider's staff when it affects or has the potential to affect the participant's care; (b) a family member of a member receiving services when it affects or has the potential to affect the member's care or services; or (c) the member receiving services
- Police arrest of the member or any person responsible for the care of the member
- A major disturbance or threat to public safety created by the member
- Any use of restraints

All service providers, including case managers, with knowledge of an incident event are required to submit an incident report through the DA web-based incident reporting system. If web access is unavailable, incidents can be reported to the DA by telephone, email, or fax. Recent changes to the incident reporting system allow for incident submission with less required information. This enhancement makes the system more accessible to participants, family members, and direct caregivers.

Additionally, 455 IAC 2 requires reporting of known or suspected abuse, neglect, or exploitation (A-N-E) of an adult to Adult Protective Services. A 24-hour hotline connected to the statewide Adult Protective Services (APS) system is available for this reporting, or reports can be made to the local APS or county prosecutor's office. A toll-free 24-hour number is available through Indiana Department of Child Services (DCS) for reporting child abuse, neglect, or exploitation.

Providers are required to suspend from duty any staff suspected, alleged, or involved in incidents of A-N-E of a participant, pending the provider's investigation of the incident. If needed, the case manager coordinates replacement services for the participant. If the case manager is the alleged perpetrator, the participant will be given a new pick list from which a new case manager will be selected.

Providers of home and community-based services are required to submit an incident report for any reportable unusual occurrence within 48 hours of the time of the incident or becoming aware of the incident. However, if an initial report involves a participant death, or an allegation or suspicion of A-N-E, it is required to be submitted within 24 hours of "first knowledge" of the incident.

Incidents are received by the DA via a secure web-based reporting system that links to the electronic incident database. Incident reporting (IR) contract staff process the incidents within one work day of receiving the reports. Processing each report includes coding the incident by type, apparent cause, resources utilized, and when applicable, perpetrator, sub-type(s), and outcome. Reviewers also determine what level of follow-up, if any, is required, and send notifications of required actions to the case manager, DA, and provider.

Required actions may include:

- Notification of APS or CPS if the incident involves A-N-E and notification is not documented in the report
- Additional follow-up by the case manager when the incident has not been resolved
- Follow-up by the DA when it appears the participant is at risk of further A-N-E or other substantial threat of harm (sentinel status). This follow-up is expected to be made by DA personnel within 48 hours of notification.
- Submission of a new report when the first report was inadequate or incomplete

The incident reviewer also sends notifications to the case manager when follow-up is not required and informs the DA of all A-N-E reports. Additional notifications may be sent to reporting entities and the DA when incident reporting requirements for timeliness are not met, or when the report should have been submitted by another party.

All incidents that are not resolved require case manager follow-up and reporting every seven days until the incident reviewer determines that the incident is resolved. Follow-up reports are also submitted via the web-based incident reporting system.

Complaint Resolution

The DA addresses complaints submitted by or on behalf of any member receiving services through a waiver administered by the DA. Complaints may be initiated by any individual through the [Incident Reporting](#) 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.

For more information on the Division of Aging's waiver incident reporting process, see the User Manual for Incident and Follow up reporting found at http://www.in.gov/fssa/files/User_Manual_for_Incident_and_Follow_Up_Reporting.pdf.

Mortality Review

As part of its Quality Assurance/Quality Improvement (QA/QI) process, participant deaths are reviewed by the DA QA/QI unit, along with any previously filed incident reports involving the participant. Additional information, including provider's records of service delivery, may be collected for further review of any unexpected deaths. If additional review is indicated, it is referred for review by the Mortality Review Committee.

The Mortality Review Committee will review all deaths that involve the participant when:

- Death is due to alleged, suspected, or known abuse or neglect
- Death is from trauma or accident
- Death is alleged or known suicide or homicide

- Death occurs unexpectedly following transition from a nursing facility
- Death occurs when participant has gone missing from normal care setting

The Mortality Review Committee may:

- Request additional information and review the case a second time when the requested information is in the file
- Close a case with recommendations for the providers or a case manager, a referral to another entity, or a systemic recommendation
- Close a case with no recommendations

All participants' deaths are required to be reported to the relevant APS unit or to the Department of Child Services (DCS), as applicable. APS units, DCS investigators, and/or law enforcement conduct independent investigations of deaths and A-N-E reports at their discretion and following their departmental protocols.

Quality Reviews

The DA conducts Provider Compliance Reviews (PCRs) for all nonlicensed waiver service providers, as well as licensed providers that also offer services that 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.

The State has contracted with a quality assurance organization to administer Person Centered Compliance Reviews and Member 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.

To assure that existing providers continue to meet provider qualifications, providers undergo a formal service review at least every three years. For licensed providers, this review is conducted by the Indiana State Department of Health (ISDH). Nonlicensed providers are reviewed by a quality assurance (QA) team contracted through the operating agency. Both ISDH and the contracted entity have formal review and remediation procedures that utilize corrective action plans (CAPs) submitted by the provider with approval or denial by the reviewing entity. If denied, the provider is required to resubmit the CAP within a two-week time frame. After it is approved, the reviewing entity verifies successful implementation of the CAP. Any provider not successfully completing the remediation process to document qualifications is decertified as a provider.

A provider's failure to cooperate with the review procedure or to complete the remediation process results 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.

Any provider decertified as a result of noncompliance with the provider agreement or failing to complete corrective actions is notified of the decision, and of his or her right to appeal. Documentation of all corrective actions taken with providers is maintained in the operating agency's Provider Database. Prior to taking action to suspend or terminate a provider, alternative service options will be provided to any affected participants through their case manager.

Quality Improvement Strategy Process

The DA 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. A provider's failure to

complete required remediation may result in sanctions up to and including termination as a waiver provider.

The QA/QI Unit, and the QA/QI Committee, recommends systemic improvements and assesses the performance of the QA/QI components.

Section 4: Financial Oversight

Waiver Audits

The State of Indiana employs a hybrid program integrity (PI) approach to overseeing waiver programs, incorporating oversight and coordination by 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 FSSA has expanded its PI activities using a multifaceted approach to SUR activity that includes provider self-audits, desk audits, and on-site audits. SUR is required to complete an initial assessment of each provider type annually. Then, based on the assessment information and referrals, audits are completed as needed. The FADS team analyzes claims data, allowing them to identify providers and claims that indicate aberrant billing patterns and 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 and 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 understanding in specific areas of concern, such as policy clarification.

The SUR Waiver Specialist is a subject matter expert (SME) responsible for directly coordinating with the waiver divisions. This specialist also analyzes data to identify potential areas of 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 reviewing waiver providers and programs.

Throughout the entire PI process, the FSSA maintains oversight. 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 IHCP and waiver requirements is available in the [Provider and Member Utilization Review](#) provider reference module.

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 regulations in 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://in.gov/attorney) at in.gov/attorney general.

Section 5: Division of Aging Waivers

Overview

The Division of Aging (DA) operates two Home and Community-Based Services (HCBS) waiver programs:

- The [Aged & Disabled \(A&D\) waiver](#)
- The [Traumatic Brain Injury \(TBI\) waiver](#)

The A&D Waiver provides an alternative to nursing facility admission for adults and persons of all ages with a disability. The waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility if waiver or other supports were not available. Waiver services can be used to help people remain in their own homes, as well as assist people living in nursing facilities return to community settings, such as their own homes, apartments, assisted living, or adult family care.

The Traumatic Brain Injury Waivers goal is to ensure that individuals with a traumatic brain injury receive appropriate services based on their needs and the needs of their families.

Indiana defines a traumatic brain injury as a trauma that has occurred as a closed- or open-head injury caused 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 that is not degenerative or congenital in 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. Indiana's definition of TBI does not include birth trauma-related injury.

Level of Care (LOC)

Aged and Disabled Waiver LOC

Persons must meet the criteria for nursing facility (NF) level of care as a key component of eligibility for the A&D waiver.

Indiana has established the Eligibility Screen (E-Screen), a tool that is used to determine basic level of care criteria that identifies nursing facility level of care. The E-Screen must be completed by the case manager from the Area Agency on Aging (AAA), as part of the LOC packet. An E-Screen will not be accepted by the computer system if all of the pages of the E-Screen have not been addressed.

Initially, the individual's physician must complete the *Physician Certification for Long Term Care Services (450B)*. The 450B includes the physician's, physician assistant's, or nurse practitioner's recommendation regarding the safety and feasibility of the individual's receiving home and community-based services.

The final LOC determination is documented in the section of the *Transmittal for Medicaid Level of Care Eligibility* form (*State Form 46018-HCBS7*).

All initial evaluations for the A&D waiver are completed by the AAA case manager, and determinations are rendered by the case manager supervisor. All initial level of care approvals are reviewed and verified by the DA staff before service implementation. Further information on the criteria necessary to meet NF level of care is outlined in [405 IAC 1-3-1](#).

Traumatic Brain Injury Waiver LOC

Persons seeking eligibility for the TBI waiver must meet NF LOC criteria, as referenced previously, for the A&D waiver (LOC); or they must meet intermediate care facility for individuals with intellectual disabilities (ICF/IID) LOC criteria. The criteria necessary to meet ICF/IID level of care is outlined in [405 IAC 1-3-1](#).

Aged & Disabled Waiver

The A&D waiver is designed to provide an alternative to NF 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 NF if waiver services or other supports were not available. Indiana's 16 AAAs act as the entry points for this waiver. The services available through this waiver are designed to help members remain in their own homes, as well as to help individuals residing in nursing facilities to return to community settings, such as their own homes, apartments, assisted living, or adult family care.

- Member eligibility
 - Individuals meeting NF LOC and Medicaid eligibility requirements must meet at least one of the following criteria to receive services through the A&D waiver:
 - Age 65 and older
 - Have a substantial physical disability
 - 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 eligibility categories are fee-for-service Medicaid categories only and may require a disability determination from the Social Security Administration.
 1. If individuals have an SSA disability determination, the state uses this determination for Medicaid eligibility purposes. Individuals considered disabled by the SSA are considered disabled by Indiana Medicaid. However, by law, Indiana Medicaid determines eligibility for individuals who apply to Indiana Medicaid without having received a Social Security Administration disability determination. Indiana Medicaid may require application to the SSA as part of the eligibility process. Members who are found eligible for Indiana Medicaid may be required to have a Social Security Administration disability determination by their next regularly scheduled Medical Review Team progress report.
 2. If the SSA's disability determination differs from Indiana Medicaid's, the SSA determination is considered final. As a 1634 state, Indiana is required to defer to all SSA disability determinations. For example, if the Medicaid agency's Medical Review Team deemed an individual to be nondisabled but the SSA later determined that same individual to be disabled and eligible for Supplemental Security Income (SSI), Indiana Medicaid would automatically enroll the individual. Individuals later found eligible for Social Security Disability Income would need to reapply, but the SSA disability determination would be accepted, and the member would be eligible if he or she met the other eligibility requirements.
- 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 TBI waiver provides home and community-based services (HCBS) 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 caused 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 that is not degenerative or congenital in 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. Indiana's definition of TBI does not including birth trauma-related injury.

- Participant eligibility
 - Waiver participants must meet the minimal NF or ICF/IID LOC requirements 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.
 - The individual must be enrolled in an IHCP fee-for-service aide category, which may require a member to have a disability determination from the Social Security Administration.
- 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

By March 17, 2022, all services will be compliant with the Centers for Medicare and Medicaid Services, HCBS Final Rule settings requirements as outlined in Indiana's Statewide Transition Plan.

Section 6: Case Management

For Aged & Disabled (A&D) and Traumatic Brain Injury (TBI) 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 (HCBS)
- 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 (NF) 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 NF 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 NF 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 Intellectual Disabilities Professional (QIDP) who meets the QIDP 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 AAA since January 1, 1990 (A&D waiver only)
- All case managers must complete the DA 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 NF 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 with common ownership or control in any other organization, entity, or individual that also delivers other in-home and community-based services under the NF 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 members.

- *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 document, 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 HCBS 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 documents, 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. DA 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 DA.
 - 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 DA 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; for example, performance appraisal process and retirement

- f) Communications that are part of supervisory oversight; for example, reinforcement of or retraining on job requirements, review of state guidelines, informational or training, sessions specific to a case, and so on
- 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.

Section 7: Service Definitions

Service Definition Overview

This section lists service definitions for the services currently approved for the Home and Community-Based Services (HCBS) Nursing Facility Level of Care waiver programs. 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 1](#) shows procedure (billing) codes and modifiers, as well as unit rates.

All settings must be compliant with the CMS Final Rule on HCBS settings. Sites certified prior to March 17, 2014, are part of the Statewide Transition Plan and must become compliant by March 17, 2019.

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

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
- 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
- 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 2 – Provider Qualifications Table for Adult Day Service

Waiver	Provider	Licensure/ Certification	Other Standard
Aged & Disabled (A&D), Traumatic Brain Injury (TBI)	Family and Social Services/ Division of Aging (FSSA/DA)-approved Adult Day Service Provider	Not required	<p>Must comply with the Adult Day Services Provision and Certification Standards, as follows:</p> <p>DA approved</p> <p>455 IAC 2 Provider qualifications: Becoming an approved provider; maintaining approval</p> <p>455 IAC 2 Provider qualifications: General requirements</p> <p>455 IAC 2 Provider qualifications: 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 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>

Adult Family Care

Service Definition

Adult family care (AFC) is a comprehensive service in which a participant resides with an unrelated caregiver so the participant may receive personal assistance. AFC is 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, but 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. The participant's needs must be addressed in a manner that supports and enables the individual to maximize abilities to function at the highest possible level of independence.

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 will provide the participant with a range of care options as his or her needs 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 allowances (PNAs) as established by the State of Indiana. The PNA is currently \$52.00 per month per IC 12-15-7-2.

A provider, after ensuring that the participants retain their PNAs, 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 2016 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)
- 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 are not 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 3 – 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	<p>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.</p> <p>DA approved</p> <p>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</p>
A&D, TBI	FSSA/DA approved Adult Family Care Agency	Not required	<p>Provider and home must meet the requirements of the Indiana Adult Family Care Service Provision and Certification Standards</p> <p>DA approved</p> <p>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</p>

Waiver	Provider	Licensure/ Certification	Other Standard
			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 when it conflicts with fire code.) Each living unit is separate and distinct. 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 PNAs, as established by the state of Indiana. The PNA is currently \$52.00 per month per IC 12-15-7-2.

A provider, after ensuring that the participants retain their PNAs, may bill participants up to the current maximum federal SSI. Providers may not charge Medicaid waiver participants a room-and-board rate that exceeds the maximum SSI rate. The maximum SSI amount for 2016 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 the 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 4 – 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 member 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 POA of a participant, HCR of a participant, or the legal guardian of a participant.
- Attendant care services will not be provided to participants receiving adult family care waiver service, structured family caregiving waiver service, or assisted living waiver service.

Provider Qualifications

Table 5 – 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 Individual	IC 16-27-4	<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>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>

Consumer-Directed Attendant Care Overtime Services

For dates of service on or after January 1, 2015, the IHCP covers consumer-directed attendant care overtime services under the A&D waiver and Money Follows the Person Aged and Disabled Waiver (MFP A&D), billed using the following Healthcare Common Procedure Coding System (HCPCS) code S5125 U7 U1 TU – Attendant care services, per 15 minutes; Waiver; ATTC; Special payment rate, overtime.

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 developing a plan and determining a baseline
- Developing 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 in implementing 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 DA
- 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 POA of a participant, the HCR of a participant, or the legal guardian of a participant.

Provider Qualifications

Table 6 – 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
- Determining 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 individual's service plan. 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 level of care (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

- 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 that 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 FSSA DA to provide direct services to individuals.

Note: Common ownership is defined as an individual, individuals, or any legal entity owning equity of at least 5% in the provider entity, as well as the institution or organization serving the provider. Control is defined as an individual or organization having 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 power is 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 POA of a participant, or the HCR of a participant, or the legal guardian of a participant.

Provider Qualifications

Table 7 – Provider Qualifications Table for Case Management

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	FSSA/DA- approved Case Management Individual	Not required	DA, or its designee, approved 455 IAC 2 Documentation of qualifications 455 IAC 2 Case management Liability insurance Training in the nursing facility LOC process by the DA or designee Education and work experience: <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) • A master’s degree in a related field may substitute for the required experience
A&D	FSSA/DA- approved Case Management	Not required	DA, or its designee, approved

Waiver	Provider	Licensure/ Certification	Other Standard
	Agency		<p>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 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 455 IAC 2 Maintenance of records of services provided 455 IAC 2 Case management</p> <p>Training in the nursing facility level of care process by the DA 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 • 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 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</p>

Waiver	Provider	Licensure/ Certification	Other Standard
			<p>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 when the person is directly responsible for his or her own living expenses in the community. Community transition services 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 when moving 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 Area Agency on Aging (AAA) or DA-approved provider 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

- 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 of 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 AFC waiver service

Provider Qualifications

Table 8 – 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, that are necessary to ensure the health, welfare, and safety of the individual, enabling the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Home Ownership

Environmental modifications must 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 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 must be authorized only when it is determined to be medically necessary and must 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 be approved only 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.
- 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, toilet meeting ADA requirements, 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 doing so 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 photographic and written documentation 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) 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, parts and labor costs funded through the waiver must be itemized clearly to differentiate which parts and labor costs are funded by the waiver service and which parts and labor are funded through a nonwaiver 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

- 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 in 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 DA-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 repair, replacement, or 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
 - 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 requires 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 parent of a minor child participant, the spouse of a participant, the POA of a participant, the HCR of a participant, or the legal guardian of a participant.

Provider Qualifications

Table 9 – 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 and permits.
A&D, TBI	FSSA/DA- approved Environmental Modification Agency/ Contractor	Any applicable licensure <i>IC 25-20.2</i> Home inspector <i>IC 25-28.5</i> Plumber Evaluator <i>IC 25-23.5</i> Certification <i>IC 25-4</i> 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	<i>IC 25-28.5</i>	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

Waiver	Provider	Licensure/ Certification	Other Standard
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 to the home, which, as indicated by individual’s service plan, are necessary to ensure the health, welfare, and safety of the individual and 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, review 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 be paid a first installment of \$300 for completion of home specifications. Once 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 which 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/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.

Note: 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 POA of a participant, the 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 an HCBS waiver.

Provider Qualifications

Table 10 – 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

Healthcare Coordination

Service Definition

Healthcare coordination includes medical coordination provided by an 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, delaying/preventing 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.

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 11 – Provider Qualifications Table for Healthcare 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 12 – 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 help the individual 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 walkways
- 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 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 POA of a participant, the 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 13 – Provider Qualifications Table for Homemaker Services

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	Licensed Personal Services Agency	<i>IC 16-27-4</i>	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 <i>IC 16-27-4</i> , if applicable.
A&D, TBI	Licensed Home Health Agency	<i>IC 16-27-1</i> <i>IC 16-27-4</i>	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, physician assistant, or nurse practitioner based on specific life stage, gender, and/or lifestyle.

Reimbursement for approved nutritional supplement expenditures is reimbursed through the local AAA, which 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 14 – 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 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 AFC waiver service, structured family care waiver service, or assisted living waiver service

Provider Qualifications

Table 15 – 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 through the local AAA, which 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 and 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 AFC waiver service
- Services to participants receiving assisted living waiver service

Provider Qualifications

Table 16 – 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 POA of a participant, the HCR of a participant, or the legal guardian of a participant.
- Payments are not made for routine care and supervision.
- Payments are not made for residential-based habilitation services to participants receiving AFC waiver service.

Provider Qualifications

Table 17 – 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 (QIDP); or a physical, occupational, or speech therapist licensed by the state of Indiana who has successfully completed training or has 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 be provided only 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 the 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 POA of a participant, the 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 AFC waiver service
- Services to participants receiving assisted living waiver service
- Services to participants receiving structured family caregiving service

Provider Qualifications

Table 18 – 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 brand covered by the Medicaid State Plan.
 - 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 a 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 that the documentation does not support the service requested.

Allowable Activities

Justification and documentation is required for the following 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 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 which parts and labor costs are provided by the waiver service and which are 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 the:
 - 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.
- 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 parts and labor costs provided by the 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, or 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 19 – Provider Qualifications Table for Specialized Medical Equipment and Supplies

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	Licensed Home Health Agency	IC 16-27-1	DA approved 455 IAC 2 Warranty required
A&D, TBI	FSSA/DA-approved Specialized Medical Equipment and Supplies Agency	IC 25-26-21 Certification IC 6-2.5-8-1	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 programs should not duplicate any services provided under the Medicaid State Plan or other waiver service.

Provider Qualifications

Table 20 – Provider Qualifications Table for Structured Day Program

Waiver	Provider	Licensure/ Certification	Other Standard
TBI	FSSA/DA-approved Structured Day Program 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 Habilitation services must be performed by persons who are supervised by a CBIS or QIDP 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.

Structured Family Caregiving

Service Definition

Structured family caregiving (SFC) means a living arrangement in which a participant lives in his or her 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 his or her abilities 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 participant’s needs 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

- SFC 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 POA of a participant, the 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 21 – Provider Qualifications Table for Structured Family Caregiving

Waiver	Provider	Licensure/ Certification	Other Standard
A&D	FSSA/DA- approved Structured Family Caregiving Agency	Not required	Provider and home must meet the requirements of the Indiana AFC Service Provision and Certification Standards. 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

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 be made only 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 that 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 be made only 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
- 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 22 – Provider Qualifications Table for Supported Employment

Waiver	Provider	Licensure/ Certification	Other Standard
TBI	FSSA/DA-approved Supported Employment Agency	Certification from the Commission on Accreditation of Rehabilitation Facilities (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

Non Medical Transportation services are services offered 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 into 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 455 IAC 2.

Limitations

Services provided under transportation services 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 23 – 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

Waiver	Provider	Licensure/ Certification	Other Standard
			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 an FSSA-approved provider.

All vehicle modifications must be approved by the waiver program before services are 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 to meet the individual’s identified needs. The following are allowed under vehicle modifications:

- Wheelchair lifts
- 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, parts and labor costs funded through the waiver must be itemized clearly to differentiate the parts and labor costs provided by waiver service from parts and labor provided through a non-waiver funding source.
- Items requested that are not previously listed must be reviewed and a 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 the:
 - 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 is 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 citizens band (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 AFC waiver service
- Services to participants receiving assisted living waiver service

Provider Qualifications

Table 24 – Provider Qualifications Table for Vehicle Modifications

Waiver	Provider	Licensure/ Certification	Other Standard
A&D, TBI	FSSA/DA approved Vehicle Modification Agency	Not required	DA approved 455 IAC 2 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; documentation of qualifications 455 IAC 2 Maintenance of records of services provided 455 IAC 2 Warranty required

Section 8: Provider Help

INsite Communication Instructions

The following are the steps for the case manager to obtain communications from the case management database, 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

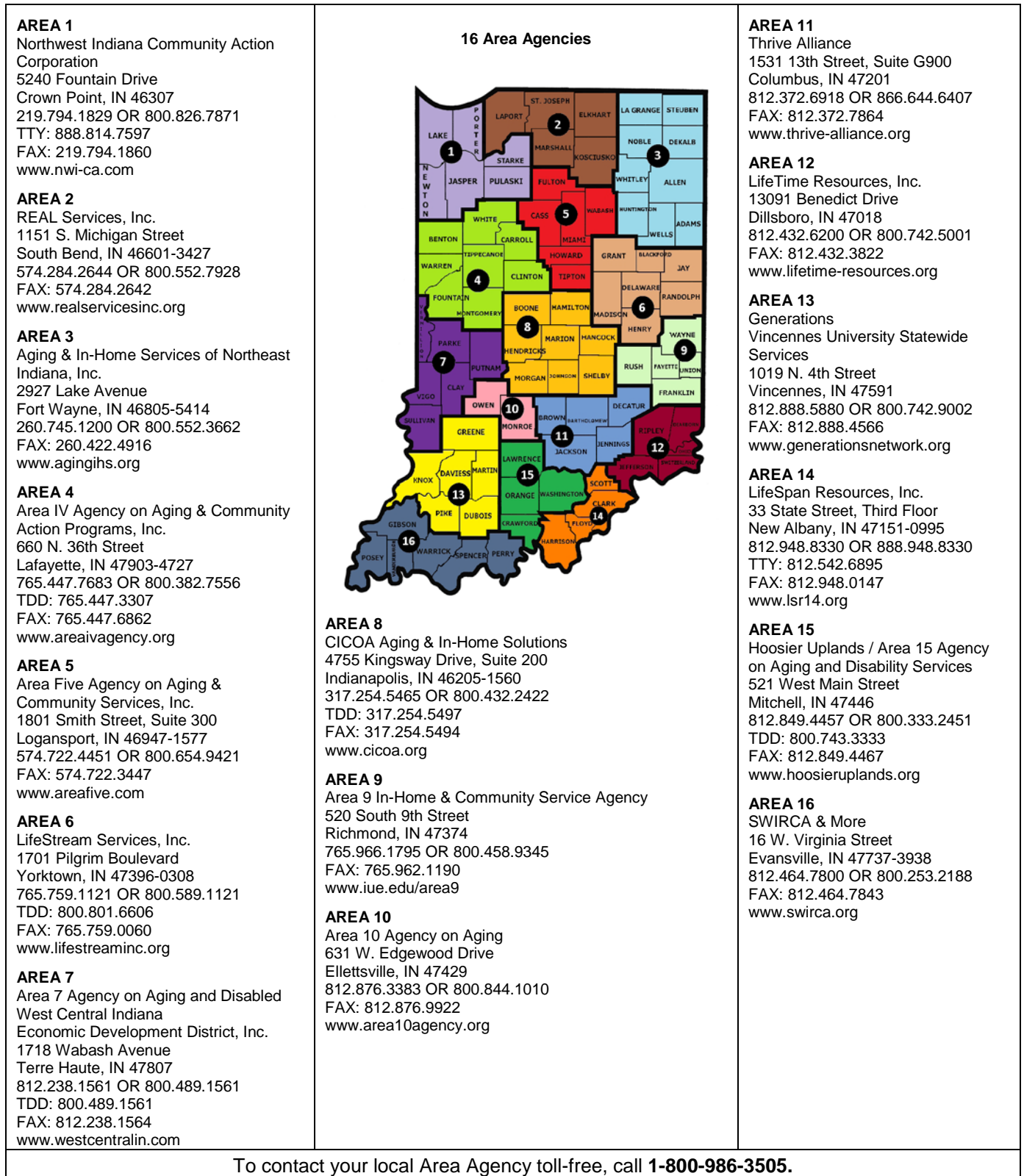
Consult the following websites for more information:

- www.in.gov/fssa – Find information by type of person in need: children, seniors, families, those with intellectual disabilities (ID), 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/3476.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 via the Incident and Follow-Up Reporting Tool.
- www.indianamedicaid.com – Find Indiana Health Coverage Programs (IHCP) provider bulletins and the *IHCP Provider Reference Modules*. Telephone contact information for providers is also available on this website.

Helpful Contact Numbers

Contact the DA at 1-888-673-0002. See Figure 1 for information on local Area Agency on Aging (AAA) offices.

Figure 1: Location and Contact Information for Local AAA Offices



To contact your local Area Agency toll-free, call **1-800-986-3505**.

Communications

General Information

The IHCP publishes the following communications to providers at indianamedicaid.com:

- IHCP *Bulletins*
- IHCP *Banner Pages* (published each week)

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