

DEPARTMENT FOR MEDICAID SERVICES  
ADULT DAY HEALTH CARE SERVICES MANUAL

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

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SECTION I

INTRODUCTION

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SECTION I - INTRODUCTION

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I. INTRODUCTION

A. Introduction

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

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

B. Fiscal Agent

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

C. General Information

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

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

SECTION II

COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

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SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

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II. COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

A. Policy

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

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

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

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

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

Each eligible medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program in accordance with 907 KAR 1:672. From those professionals who have chosen to participate, members may select the provider from whom they choose to receive their medical care.

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

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

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

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

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

All services provided to Medicaid members shall be on a level of care that is equal to that extended private pay individuals or others,

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and on a level normally expected of a person serving the public in a professional capacity.

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

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

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

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

B. Appeal Process for Refund Requests

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

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

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

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

C. Timely Submission of Claims

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

Claims should be submitted to:

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

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D. Kentucky Patient Access and Care System (KenPAC)

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

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

E. Lock-In Program

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

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

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

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

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

G. Kentucky Health Care Partnership Program

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

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

H. EMPOWER Kentucky Transportation Initiative

In accordance with 907 KAR 3:065, the Department shall implement, within the Medicaid Program, as an EMPOWER

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

### SECTION III

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

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

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

A. Waiver Requested

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

B. Individual's Freedom of Choice

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

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

The MAP-350 form is utilized to document that choice was given to the individual.

C. Target Population and General Financial and Waiver Eligibility Requirements

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

The eligibility groups include the mandatory categorically needy and optional categorically needy. This shall include the aged, blind

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and disabled individuals and persons determined eligible under the Aid to Families with Dependent Children (AFDC) category and AFDC related categories.

1. Medicaid Eligibility Process

- (a) The DMS shall notify the individual, the provider and the Department for Community Based Services (DCBS) when the individual has been determined appropriate for waiver services, the effective date and the monthly cost of the requested services.
- (b) The individual and family or responsible party shall be advised to make application for eligibility at the DCBS office in the county where the individual lives in order to ensure Medicaid coverage for services. At the time of application, the applicant (spouse or interested party representing the member) should bring proof of social security number, income (unearned or earned), resources, life insurance, and medical bills.
- (c) The DCBS is required to complete an assessment of the countable resources of the individual and the spouse. This assessment includes a comparison of the combined countable resources to the current Medicaid resource allowance for the waiver member and the non-waiver spouse to determine if the member meets resource eligibility for Medicaid.
- (d) Resources are defined as cash money, and any other personal property or real property that an individual or couple owns; has the right, authority or power to convert to cash; and is not legally restricted from using for support and maintenance. Resources may include but are

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not limited to: checking and savings accounts, stocks or bonds, certificates of deposit, automobiles, land, buildings, burial reserves, and life insurance policies.

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

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their basic maintenance needs an amount equal to the SSI basic benefit rate plus the SSI general disregard. This allowable maintenance amount shall change if the SSI benefit rate or standard deduction changes. The patient liability for the month of admission to the waiver, however, would usually be zero with the following exceptions:

- (1) Community deeming rules for Medicaid eligibility shall be used for the month of admission for all waiver members who are either married or under the age of eighteen (18). This means that the income and resources of the spouse or parent shall be considered to be available for the month of admission only. For the second month and each succeeding month of waiver participation, only the income and resources of the member shall be used to determine Medicaid eligibility.
- (2) The member has been discharged from a nursing facility, ICF/MR/DD facility, hospice program or another waiver program, within thirty (30) days of the effective date for Home and Community Based (HCB) Waiver services.
  - (i) The individual should indicate to the DCBS that they are applying for eligibility under the special income category of the waiver.
  - (j) The member and family or responsible party shall be advised of the importance of contacting the local DCBS office in the following situations:

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- (1) The member's Medicaid eligibility was based upon a recent nursing facility admission.
- (2) The member's Medicaid eligibility was based upon the "Spend-Down" category of eligibility.
- (3) The member's Medicaid eligibility was based upon SSI eligibility.
- (4) Whenever there is a change in the member's circumstance.

2. Member's Continuing Income Liability

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

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

3. Waiver Eligibility Determination

- (a) An individual may be referred for waiver services by the individual themselves, the individual's legal representative or the individual's attending physician.

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

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

- (d) The HCB Waiver provider, individual member, and DCBS shall receive notification from the PRO of the denial for NF level of care. If the individual/member or legal representative disagrees with the adverse determination, the member shall have the right to an appeal in accordance with 907 KAR 1:563.
- (e) For acute care hospital inpatients whose care needs indicate that nursing facility services may be required, hospital discharge planners

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SECTION III – OVERVIEW OF THE HOME AND COMMUNITY BASED  
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are requested to refer the individual to an HCB Waiver provider of their choice.

- (f) It shall be the NF's responsibility to ensure that all members are informed of the availability of waiver services as an alternative prior to admission to the NF and annually thereafter.
- (g) Waiver services shall not be provided to an individual who is an inpatient of a hospital, NF, intermediate care facility for individuals with mental retardation or developmental disabilities (ICF/MR/DD) or enrolled in a Medicaid covered Hospice program. An individual who is a resident of a licensed personal care home or family care home or who is receiving a service in another Medicaid waiver program shall not be eligible to receive HCB Waiver services.
- (h) A waiver provider shall notify the local DCBS office and the PRO on a MAP-24 form if a member is terminated from the waiver program or if the member is admitted for less than sixty (60) consecutive days to a NF and is returning to the waiver program. A member who remains in a NF longer than sixty (60) consecutive days shall be terminated from the waiver program. If the member requests readmission to the waiver program after sixty (60) consecutive days all procedures for a new admission shall be followed.
- (i) The DMS may exclude an individual for whom the aggregate cost of waiver services would reasonably be expected to exceed the cost of NF services.

## SECTION IV

### CONDITIONS OF PARTICIPATION

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SECTION IV – CONDITIONS OF PARTICIPATION

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IV. CONDITIONS OF PARTICIPATION

A. Participation Overview

To participate in the HCB Waiver Program, an Adult Day Health Care (ADHC) provider shall meet the licensure requirements in accordance with 902 KAR 20:066, 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:160.

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

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

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

B. Provider Freedom of Choice

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

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C. Overview of Record Requirements

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

1. Clinical Records

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

The ADHC clinical record shall contain:

- (a) The member's name, address, and MAID number;
- (b) The name, address, and telephone number of the member's case manager;
- (c) Name and telephone number of the member's personal physician;
- (d) The member's medical, nursing and social history and physical examination report;
- (e) The member's medication and food allergies;
- (f) Documentation of each service provided which shall include:
  - (1) The date the service was provided;
  - (2) The duration of the service;

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- (3) The arrival and departure time of the member;
- (4) Description of service(s) provided;
- (5) The title and signature of the service provider.
- (g) Name, telephone number, and address of the next of kin or other responsible person;
- (h) Date of admission and discharge;
- (i) A progress record which shall be maintained stating goals for a member and shall include:
  - (1) Changes in the patient's condition, behavior, responses, attitude, appetite, and other changes as noted by staff;
  - (2) A discharge summary; and
  - (3) All entries signed and dated.
- (j) Physician orders;
- (k) A current care plan which shall include:
  - (1) Special diet;
  - (2) Contraindications for specific types of activities; and
  - (3) Other special procedures required for the safety and welfare of the patient.
- (l) A medication administration sheet which shall contain:
  - (1) The date medication was given;
  - (2) Time medication was given;

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- (3) Name of medication;
  - (4) Dosage;
  - (5) Name of prescribing physician; and
  - (6) Name of staff administering the medication.
- (m) A full written incident report involving the patient.
2. Personnel Records
- The ADHC provider shall be required to retain a confidential personnel record for each staff person. Personnel records at minimum should include a copy of current license, if applicable, and documents as specified in 902 KAR 20:066, Section 2(4). Documentation shall be maintained in each personnel file that the staff member is free of communicable disease. If the employee contracts a communicable disease, they shall not be permitted to provide a service to a member until the condition is determined not to be contagious. The personnel file may be subject to review by the department.
3. Records Accessibility
- The ADHC provider shall make information regarding service and financial records available to:
- (a) The Department for Medicaid Services, or its designee;
  - (b) The Commonwealth of Kentucky, Cabinet for Health Services, Office of Inspector General, or its designee;
  - (c) The United States Department for Health and Human Services, or its designee;
  - (d) The United States General Accounting Office, or its designee;

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- (e) The Commonwealth of Kentucky, Office of the Auditor of Public Accounts, or its designee; and
- (f) The Commonwealth of Kentucky, Office of the Attorney General, or its designee.

D. Provider Requirements

ADHC providers shall maintain a policy and procedures manual outlining policies which includes agency hours of operation, emergency contact, contingency plan(s) for emergencies and to accommodate back-up when usual care is unavailable, agency fee schedule and other pertinent agency operational information. ADHC providers shall ensure availability of their manual to agency staff, members, family members or any other interested parties. Agency policy and procedure manuals may be subject to review by the Department.

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

1. Abuse, neglect or exploitation of a member;
2. Falls;
3. Medication errors;
4. Medical emergencies;
5. Equipment malfunction;
6. Breakage or damage to member's property;
7. Alleged/suspected theft;
8. Adverse/allergic drug reactions;
9. Communication errors;
10. Accidents involving members or visitors

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11. Incidents caused by the member such as verbal and/or physical abuse of staff or other members, destruction or damage of property and member self-abuse.

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

1. ADHC providers shall develop a process for reporting all incidents. This process shall include the development of a standardized form and instructions to be utilized by agency staff members when reporting an incident. ADHC providers shall maintain a copy of the incident report in the member's clinical record and the ADHC provider's central file. The central file shall contain all of the ADHC provider's incident reports in chronological order in a binder for a period of one (1) year. After which time, the incident reports shall be kept readily available for review in an accessible storage area for five (5) years.
2. ADHC providers shall be responsible for implementing a procedure which ensures the reporting of a complaint against an agency or its personnel by a member or interested party. ADHC providers shall make available to agency staff, members or interested parties the Office of Inspector General Hotline number which is 1-800-635-6290.

ADHC providers shall ensure that a copy of each incident report is provided to the member or legal representative and to the attending physician, PA, or ARNP who shall review the reports.

SECTION V  
ADULT DAY HEALTH CARE COVERED SERVICES

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SECTION V – ADULT DAY HEALTH CARE COVERED SERVICES

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V. ADULT DAY HEALTH CARE COVERED SERVICES

A. General Information

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

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

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

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

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

B. Conformance with physician's orders

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

C. Change in Condition

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

D. ADHC Basic Services

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

1. Skilled nursing services provided by an RN or LPN which may include:
  - (a) Ostomy care;
  - (b) Urinary catheter care;
  - (c) Decubitus care;
  - (d) Tube feeding;
  - (e) Venipuncture;
  - (f) Insulin injections;

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- (g) Tracheotomy care; and
  - (h) Medical monitoring
2. Meal service corresponding with hours of operation with a minimum of one (1) meal per day and therapeutic diets as required;
  3. Snacks;
  4. Age and diagnosis appropriate daily activities which shall include:
    - (a) A variety of planned activities for ADHC members according to age, functional level and their plan of care. The activities should be designed to maximize strengths and appeal to present and former interests;
    - (b) A program that may be led by various ADHC staff members but the ultimate responsibility for the planning and implementation of the program is that of the ADHC's health team;
    - (c) A monthly activity calendar provided for the convenience of members, families, ADHC staff and potential ADHC members. It shall be posted in an accessible, visible location and enlarged so that it may be easily read.
  5. Routine services that meet the daily personal and health care needs of an ADHC member and shall include, but are not limited to:
    - (a) Monitoring of vital signs;
    - (b) Assistance with activities of daily living;

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- (c) Monitoring and administration of self-administered medications;
- (d) Therapeutic programs; and
- (e) Incidental supplies and equipment needed by the ADHC member.

E. Reimbursement for Basic Services

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

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

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

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

- (a) The individual must have a substantial disability that manifested before the individual reaches twenty-two (22) years of age;

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(b) The individual must have a disability that shall be attributable to mental retardation or a related condition which shall include:

- (1) Cerebral palsy;
- (2) Epilepsy;
- (3) Autism; or
- (4) A neurological condition that results in an impairment of general intellectual functioning or adaptive behavior, such as mental retardation, which significantly limits the individual in two (2) or more of the following skill areas:
  - a) Communication;
  - b) Self-care;
  - c) Home-living;
  - d) Social skills;
  - e) Community use;
  - f) Self direction;
  - g) Health and safety;
  - h) Functional academics;
  - i) Leisure; or
  - j) Work; and

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- (5) An adaptive behavior limitation similar to that of a person with mental retardation, including:
- a) A limitation that directly results from or is significantly influenced by substantial cognitive deficits; and
  - b) A limitation that may not be attributable to only a physical or sensory impairment or mental illness.

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

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

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

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

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

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

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

F. Assessment Service

Assessment services shall include a comprehensive assessment which shall:

- (a) Identify the member's needs and the services that a member or family cannot manage or arrange;
- (b) Evaluate the member's physical health, mental health, social supports, and environment;
- (c) Be requested by an individual requesting HCB waiver services, a family or legal representative of the individual, the individual's physician, a Physician's Assistant, or an ARNP;

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- (d) Be conducted, within seven (7) calendar days of receipt of the request for assessment, by an assessment team comprised of two Registered Nurses (RN) or an RN and a qualified social worker, certified psychologist with autonomous functioning, licensed psychological practitioner, licensed marriage and family therapist or licensed professional clinical counselor. The social worker shall be qualified on the basis of the ADHC provider's determination using the criteria specified in 907 KAR 1:160. At a minimum, the social worker shall have a bachelor's degree in social work, sociology or a related field.
  
- (e) Include at least one (1) face-to-face contact with the member and, if appropriate, the family. This contact shall be conducted by the RN, qualified social worker, certified psychologist with autonomous functioning, licensed psychological practitioner, licensed marriage and family therapist or licensed professional clinical counselor in the individual's home . The contact may begin in the hospital, nursing facility, the member's home or another place of residence at the time but shall be completed in a home visit. Person(s) may assist in gathering the information for the assessment process when the HCB Waiver Provider has determined that the person(s) is capable of performing this task.
  
- (f) HCB Waiver packets received more than sixty (60) calendar days after the date of the assessment shall be returned unreviewed and a new assessment shall be completed.

The assessment service shall be billed using the HCPCS Code T1028, per unit of service. One (1) unit of service represents the entire comprehensive assessment process.

G. Reassessment Service

The reassessment service:

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1. Shall be performed at least every twelve (12) months or more often, if indicated by a change in the member's condition;
2. Shall determine the continuing need for HCB waiver services;
3. Shall be conducted using the same procedures as for an assessment service;
4. Shall be initiated by a waiver provider who shall:
  - (a) Notify the department no more than three (3) weeks prior to the expiration of the current level of care certification;
  - (b) Assume responsibility to inform the PRO of the current through date at the time of the telephone call to ensure that the new certification period is consecutive;
  - (c) Submit the reassessment information to the PRO within fourteen (14) calendar days of the verbal level of care certification. If all criteria are met, the PRO shall evaluate the reassessment material and authorize continued coverage for the HCB Waiver services. The PRO will not issue a retroactive prior authorization of services for packets not received within the set timeframes; and
  - (d) Not be reimbursed for a service provided during a period that an HCB member is not covered by a valid level of care certification.
5. Shall not be retroactive. Meaning any member for whom recertification has not been requested by the end date of the

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current certification period shall experience a period of ineligibility for waiver services.

6. May be effective on the date of the telephone call to the PRO, if no more than sixty (60) calendar days have elapsed since the end of the previous certification period and other recertification criteria are met.

If more than sixty (60) calendar days have elapsed since the end of the previous certification period, the member shall be considered to be terminated from the HCB Waiver program. In order for the member to be readmitted to the HCB Waiver program the provider shall follow the steps for an initial admission.

H. Case Management

1. Definition of Case Management

Case Management shall be a system under which a designated qualified individual is responsible for location, coordination and monitoring a group of services.

Effective case management is the management and coordination of the delivery of all services to the HCB Waiver member. These services include direct waiver member services provided by the waiver provider as well as all other services included in the member's plan of care, transportation, volunteer services, informal support services, physician or clinic visits. It may also include arranging for drugs, supplies or related medical equipment.

A quality case management system eliminates fragmentation and duplication of patient services; ensures the continuity of necessary services; monitors all aspects of patient care; observes changes in condition or unmet needs; ensures the most appropriate and cost-effective patient care; facilitates a

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close and positive relationship with the HCB Waiver member; and, affords the member and legal representative the security that a qualified individual understands their needs and will assist them as needed. The provider shall designate a case manager.

1. Care planning resulting in the development of a plan of care that shall:
  - (a) Reflect the needs of the waiver member;
  - (b) List goals, interventions and outcomes as related to the waiver member's identified needs;
  - (c) Be in place prior to the provision of services;
  - (d) Specify the services needed by the member;
  - (e) Determine the amount, frequency, and duration of services;
  - (f) Contain provisions for reassessment at least every twelve (12) months;
  - (g) Have input from other persons which may include other professionals and home health aides;
  - (h) Be reviewed and signed by the attending physician, PA, or ARNP; and
  - (i) Be submitted to the department within fourteen (14) calendar days of receiving the department's verbal approval of nursing facility level of care. The PRO will not issue a retroactive prior authorization of services for packets not received within the set timeframes.
  
2. Case Manager Qualifications and Responsibilities

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The case manager shall be an RN, LPN, a qualified social worker, certified psychologist with autonomous functioning, licensed psychological practitioner, licensed marriage and family therapist or a licensed professional clinical counselor. Case managers shall have intensive knowledge of the member, family and the community.

The case manager shall be responsible for locating the needed available resources. These resources may be formal health and social agencies or informal family and community supports. The case manager has the responsibility to:

- (a) Bring the waiver member's needs to the attention of the appropriate referral source and to the appropriate staff within the provider agency;
- (b) Coordinate, manage and monitor the delivery of services to the waiver member including working with the family and other informal caregivers;
- (c) Have regular contact with each waiver member either by telephone or by home visits (all contacts shall be documented in the member's record);
- (d) Link waiver members with informal community services (e.g., neighborhood helping networks, churches, schools, civic organizations, volunteers, etc.) to maximize the use of community resources;
- (e) Promote family involvement in meeting the health care needs of the waiver member;
- (f) Consult as needed with others involved in the provision of services;

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- (g) Actively participate in the assessment and reassessment processes; and
- (h) Seek alternative arrangements as the waiver member's needs dictate.

A case manager shall be designated in each waiver member's clinical record.

Each waiver member shall have at least one (1) case management contact per month to assess the service delivery. The contact may be made by telephone or face-to-face. However, a face-to-face contact with the HCB Waiver member shall be made at least every other month. The face-to-face contact with the waiver member may be made while the member is at the ADHC.

Case management shall be face-to-face or telephone contact with the member or with resources. Group conferences shall **not** be billable as case management services.

The case management shall be documented in the medical record to include the reason for the case management service and a reflection of its impact upon the waiver member's plan of care. There shall also be documentation of the service provided and the actual time for each billable service.

3. Reimbursement for Case Management Service

Case management shall be billed using HCPCS Code T1016 per unit of service. One (1) unit of service is equal to fifteen (15) minutes.

An **initial** unit of service that is less than fifteen (15) minutes may be billed as one (1) unit. After the initial unit, any service time less than fifteen (15) minutes shall be rounded down.

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I. Therapy Services

The ADHC shall provide therapy services in accordance with 907 KAR 1:023. As appropriate, physical, occupation or speech therapy may be provided by ADHC provider under contractual arrangement with a qualified therapist in accordance with the plan of treatment. It is expected that these services shall consist of evaluation (reevaluation), for the purpose of developing a plan which could be carried out by the ADHC member or ADHC staff. However, individualized therapy services provided by the therapist to an ADHC member in accordance with the plan of treatment may be covered. The qualified therapist shall assist the physician in evaluating the level of function, help develop the plan of treatment (revising as necessary), prepare clinical and progress notes, advise and consult with other ADHC personnel and participate with in-service programs. Therapy services shall be reasonable, rehabilitative, and necessary for the ADHC member's condition and of such complexity that the service must be performed by a qualified therapist. A maintenance program must be developed for the performance of procedures, which could be safely and effectively carried out by the ADHC member, caregiver or ADHC staff. Each ADHC center shall have a private area for therapy services to be provided.

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

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

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3. Speech therapy provided by a speech pathologist who is qualified and appropriately licensed by the Commonwealth of Kentucky as established in 902 KAR 20:066.

J. Reimbursement for Therapies

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

K. Respite Service

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

L. Reimbursement for Respite Service

One (1) unit is equal to fifteen (15) minutes to twenty-nine (29) minutes. ~~one (1) hour to one (1) hour and fifty-nine (59) minutes.~~ Two (2) units is equal to thirty (30) minutes to forty-five (45) minutes. ~~two (2) hours to two (2) hours and fifty-nine (59) minutes.~~

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

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

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