

907 KAR 3:100
Material Incorporated by Reference

Acquired Brain Injury Services and Reimbursement Program Manual
(September 2002 edition)

Filed: SEPTEMBER 13, 2002

EFFECTIVE DECEMBER 18, 2002

**KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY SERVICES
AND
REIMBURSEMENT PROGRAM MANUAL**

**Cabinet for Health Services
Department for Medicaid Services
Frankfort, Kentucky 40621**

**TRANSMITTAL #3
09/02**

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

TABLE OF CONTENTS

	PAGE NO.
I. INTRODUCTION	1.1
A. Introduction	1.1
B. Fiscal Agent	1.1
C. General Information	1.1
II. KENTUCKY MEDICAID PROGRAM	2.1-2.7
A. Policy	2.1
B. Appeal Process of Refund Requests	2.3
C. Timely Submission of Claims	2.4
D. Kentucky Patient Access and Care System(KenPAC)	2.5
E. Lock-In Program	2.5
F. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program	2.6
G. Kentucky Health Care Partnership Program	2.6
H. EMPOWER Kentucky Transportation Initiative	2.7
III. OVERVIEW OF THE ACQUIRED BRAIN INJURY (ABI) WAIVER PROGRAM	3.1-3.11
A. Waiver Requested	3.1
B. Program Goal	3.2
C. Definition of Acquired Brain Injury	3.2
D. Acquired Brain Injury (ABI) Program Objective	3.2
E. Acquired Brain Injury (ABI) Waiver Services Availability	3.2
F. Individual's Freedom of Choice	3.3
G. Acquired Brain Injury (ABI) Waiver Target Population	3.3

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

TABLE OF CONTENTS

	PAGE NO.
IV. CONDITIONS OF PARTICIPATION	4.1-4.46
A. Participation Overview	4.1
B. Out-of-State Providers	4.1
C. Acquired Brain Injury Waiver Provider Agency Qualifications	4.1
D. Ineligibility for ABI Waiver Provider Participation	4.2
E. Termination of ABI Waiver Provider Agency Participation	4.3
F. Record Requirements	4.3
G. General Service Provider Qualifications and Requirements	4.4
H. Licensed, Certified or Degreed Professional Staff Qualifications	4.5
I. Crisis Prevention and Response Plan	4.6
J. Incident Reporting	4.6
K. Behavioral Programming and Support	4.7
L. Safety	4.10
M. Provider Agency Qualifications, Personnel Qualifications, and Services Definitions	4.12
V. ACQUIRED BRAIN INJURY WAIVER SERVICE COVERAGE REQUIREMENTS	5.1-5.6
A. Prior Authorization Procedures	5.1
B. Approval	5.3
C. Denials	5.4
D. Modifications	5.4
E. Re-evaluation	5.4
F. Terminations	5.5
VI. REIMBURSEMENT	6.1-6.2
APPENDICES	
APPENDIX I	Physician Certification Form (MAP-4099) I
APPENDIX II	Long-Term Care Facilities and HCB Certification Form (MAP-350) II

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

TABLE OF CONTENTS

APPENDICES (Continued)

APPENDIX III	Rancho Scale	III
APPENDIX IV	Applicant/Recipient Memorandum of Understanding Form (MAP-4096)	IV
APPENDIX V	Acquired Brain Injury Plan of Care Form (MAP-4097)	V
APPENDIX VI	Acquired Brain Injury Plan of Care Modification Form (MAP-4098)	VI
APPENDIX VII	Request for Equipment Form (MAP-95)	VII
APPENDIX VIII	Department for Community Based Services Form and Instructions (MAP-24B)	VIII
APPENDIX IX	Request for KSP Conviction Date Only/Employment	IX
APPENDIX X	Incident Report Form, Codes, and Instructions	X (1 – 4a)

SECTION I - INTRODUCTION

I. INTRODUCTION

A. Introduction

The Kentucky Medicaid Program Acquired Brain Injury Services and Reimbursement Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid recipients in the Acquired Brain Injury Waiver program.

This manual shall provide basic information concerning coverage, policy and reimbursement. 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 recipients.

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 recipients of all ages. Kentucky Medicaid coverage and limitations of covered health care services specific to the Acquired Brain Injury Waiver Program shall be specified in this manual.

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

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 recipients.

The Medicaid Program shall be the payor of last resort. If the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient'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 recipient, 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, recipients may select the provider from whom they wish to receive their medical care.

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

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 recipient, and a payment for the same service shall not be accepted from the recipient. The provider may bill the recipient 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 patient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the patient'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 patient, 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 recipient prior to a service being rendered may result in a provider being out of compliance with 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.

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

All services provided to eligible Medicaid recipients shall be on a level of care that is equal to that extended private patients, and on a level normally expected of a person serving the public in a professional capacity.

All recipients 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 recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of their liability for the charges for non-medically necessary and non-covered services.

If a recipient 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 recipient 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 :

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

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

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

1-800-807-1232 – Provider Assistance

D. Kentucky Patient Access and Care System (KenPAC)

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

E. Lock-In Program

The Department shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient. The Department shall investigate all complaints concerning recipients 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 recipient 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 recipients shall comply with the provisions set forth in 907 KAR 1:677, Medicaid Recipient Lock-In.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services. Recipients 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.

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)

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

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 1396d(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 implemented, within the Medicaid Program, a capitation managed care system for physical health services 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 recipients receiving waiver services, as well as nursing facility and long term care services are exempt from participation in a capitation managed care system. These recipients receive services through the traditional Medicaid program.

H. EMPOWER Kentucky Transportation Initiative

In accordance with 907 KAR 3:066, the Department shall implement, within the Medicaid Program, as an EMPOWER 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

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

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 THE ACQUIRED
BRAIN INJURY (ABI) WAIVER PROGRAM

III. OVERVIEW OF THE ACQUIRED BRAIN INJURY (ABI) WAIVER
PROGRAM

A. Waiver Requested

The Department for Medicaid Services requested that the Secretary of the United State 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 for persons with a primary diagnosis of acquired brain injury. A Medicaid eligible recipient with an acquired brain injury who qualifies for nursing facility level of care may receive the following home- and community-based services if stipulated in his individualized plan of care:

1. Case management.
2. Personal care services.
3. Respite care services.
4. Companion services.
5. Structured day program services.
6. Supported employment services.
7. Behavior programming.
8. Counseling.
9. Occupational therapy, Speech, Hearing,
Language services.
10. Specialized medical equipment and supplies.

SECTION III - OVERVIEW OF THE ACQUIRED
BRAIN INJURY (ABI) WAIVER PROGRAM

- 11. Environmental modifications.
- 12. Community residential services.

B. Program Goal

The goal of the Acquired Brain Injury (ABI) Waiver Program is to rehabilitate and reintegrate individuals with an acquired brain injury into the community with the availability of existing community resources when discharged from the ABI Waiver Program.

C. Definition of Acquired Brain Injury

Acquired brain injury is an injury with structural, non-degenerative brain damage. This injury is one that is not hereditary, congenital or degenerative, and it is an injury that occurs after birth.

This injury results in damage to an area of the brain that may diminish or alter the individual's state of consciousness which results in an impairment of cognitive abilities and physical functioning. It can also result in a disturbance in the individual's behavioral and emotional functioning. These impairments may be temporary or permanent, and cause various degrees of functional disability or maladjustment.

An acquired brain injury is not a disease process that results in deterioration of the brain and its function.

D. Acquired Brain Injury Program Objective

The objective of the ABI Waiver Program is to prepare and to assist individuals with an acquired brain injury, who have a potential for rehabilitation and reintegration into the community, and who can live in the community with the assistance of needed resources available in the community.

E. Acquired Brain Injury (ABI) Waiver Services Availability

The ABI Waiver Program is a statewide program. Any provider agency that meets all applicable Medicaid requirements and is

SECTION III - OVERVIEW OF THE ACQUIRED
BRAIN INJURY (ABI) WAIVER PROGRAM

Medicaid certified may participate in the ABI Waiver Program.

F. Individual's Freedom of Choice

An individual eligible to receive acquired brain injury waiver services and his legal representative shall be given a choice to:

- (1) Receive home- and community-based services or nursing facility services; and
- (2) Select participating ABI waiver providers from whom he wishes to receive services.

G. Acquired Brain Injury (ABI) Waiver Target Population

1. Definition of Individuals to be Served

Eligibility for ABI waiver services shall be considered only for individuals with an acquired brain injury who are currently receiving inpatient services in a nursing facility or a nursing facility/brain injury (NF/BI) program, or who are in the community and have potential for inpatient services in a nursing facility or nursing facility/brain injury (NF/BI) program. These individuals' care needs shall be within the scope of Medicaid level of care criteria for nursing facility benefits as determined by the Medicaid Program's designated Peer Review Organization (PRO). In addition, these individuals shall meet the eligibility requirements for ABI waiver services.

The level of care provided in a NF and covered under the Medicaid Program is defined in 42 CFR 440.40 and 440.150. Recipients and potential recipients shall be advised of the availability of the Acquired Brain Injury Waiver Program services option. Medicaid eligible individuals with an acquired brain injury, who are currently residing in a nursing facility and continue to meet the nursing facility level of care criteria, may receive ABI waiver services upon discharge from the facility if the services are required in order for them to re-enter the community.

SECTION III - OVERVIEW OF THE ACQUIRED
BRAIN INJURY (ABI) WAIVER PROGRAM

The population to be served are individuals twenty-one (21) to sixty-five (65) years of age with cognitive, behavioral or physical impairments which necessitate supervised and supportive services. An individual who sustained his injury prior to age 21 may be eligible for ABI waiver services. Excluding congenital injuries, there is no restriction with regard to the age of the individual at the time of the injury.

The State will refuse to offer acquired brain injury waiver services to any individual for whom it can reasonably be expected that the cost of the acquired brain injury services furnished to that individual would exceed the cost of providing the required services in the appropriate institutional level of care. The cost-effective evaluation takes into consideration all Medicaid covered services required by the individual.

An individual, while an inpatient of a hospital, nursing facility or an intermediate care facility for persons with mental retardation, or while receiving services in another home and community based waiver program shall not be eligible to receive acquired brain injury waiver services.

2. General Financial Eligibility Requirements

- (a) Individuals who are already Medicaid eligible and have a current Medicaid identification card would meet the financial eligibility requirements for the ABI Waiver Program.
- (b) Individuals whose income does not exceed 300% of the SSI payment standard may be financially eligible.
- (c) The Medicaid resource limits that are applicable to covered Medicaid recipients residing in nursing facilities are also applicable to ABI waiver recipients.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION III - OVERVIEW OF THE ACQUIRED
BRAIN INJURY (ABI) WAIVER PROGRAM

(d) The spousal impoverishment rules that apply to nursing facility residents also apply to ABI waiver recipients.

3. Treatment of Income and Resources of Target Population

Individuals served under this waiver shall be categorically needy, eligible under the special income level group as specified in 42 CFR 435.217, or medically needy.

The financial eligibility determinations for the special income provision shall be made in the same manner as determinations are made for NF, ICF/MR/DD and all home- and community-based waiver programs.

Institutional deeming rules used for nursing facilities shall be applied to acquired brain injury waiver recipients. Waiver recipients shall be allowed to retain from their own income for their basic maintenance needs, an amount equal to the Supplemental Security Income (SSI) basic benefit rate plus the SSI general disregard amount. This allowable maintenance amount shall change if the SSI benefit rate or standard deduction amount changes. The patient liability for the month of admission to the waiver will be zero, unless the individual is transferring from another home- and community-based waiver program or a nursing facility.

If there is a community spouse and only one member of the couple is in the waiver program, only the income of the waiver recipient shall be used to determine Medicaid eligibility. Resources shall be considered in accordance with the spousal impoverishment provision.

If a recipient is being considered for eligibility based upon the special income criteria, the ABI waiver services provider shall follow the usual procedures for admission to the ABI Waiver Program.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION III - OVERVIEW OF THE ACQUIRED
BRAIN INJURY (ABI) WAIVER PROGRAM

In order to ensure service coverage, the recipient, a family member, or his legal representative or other responsible party shall be advised of the need to make application at the local Department for Community Based Services (DCBS) office. They should inform the local DCBS office that they are applying for eligibility under the special income category of the Acquired Brain Injury Waiver Program.

NOTE: The recipient, family member, his legal representative or other responsible party shall be advised of the importance of contacting the local DCBS office in the following situations:

- (a) The recipient's Medicaid eligibility is based upon a current nursing home stay;
- (b) The recipient's eligibility is based upon participation in another home- and community-based waiver program;
- (c) The recipient's Medicaid eligibility is based upon the "Spend-Down" category of eligibility;
- (d) If an individual is not currently receiving Medicaid benefits; or
- (e) If there is a change in the individual's situation that may affect his eligibility.

The individual or his legal representative shall notify the local DCBS office of admission to the Acquired Brain Injury Waiver Program, so that DCBS can determine if a further application for Medicaid eligibility under the special income provision of the ABI Waiver Program is required.

4. Recipient's Continuing Income Liability

If it is determined by the DCBS office that a recipient has a

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION III - OVERVIEW OF THE ACQUIRED
BRAIN INJURY (ABI) WAIVER PROGRAM

continuing income liability, this amount shall be paid to the designated provider by the recipient or responsible party and shall be deducted monthly from the ABI Waiver Program payments to the provider. Notification of the amount of the continuing income shall be forwarded to the designated provider on a MAP-552 form. It is the responsibility of the provider agency to collect this money from the recipient. The identification of the provider agency responsible for collecting the individual's available continuing income, as indicated on the MAP 552, shall be based on the highest monthly cost of service delivery.

5. General Outline of Waiver Eligibility Determination

It is recognized that there may be situations in which:

- (a) The recipient and family shall not wish to consider the ABI waiver services; or
- (b) ABI waiver services clearly would not be an alternative for consideration.

If the individual chooses to consider the ABI Waiver Program option, a referral shall be made to the case management agency of the individual's choice.

Inquiries pertaining to the need for services may be received by a variety of State and other agencies. If it appears that the individual, his family or his responsible party are interested in receiving ABI waiver services, a referral should be made to a Medicaid participating ABI waiver program case management agency.

The ABI case management agency may receive referrals from any source, including the individual and his family. Prior to the level of care determination, subsequent assessment and the plan of care process, the individual's attending physician shall be contacted to obtain his recommendation

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION III - OVERVIEW OF THE ACQUIRED
BRAIN INJURY (ABI) WAIVER PROGRAM

and certification using the MAP-4099 form.

Eligible recipients and Medicaid applicants with acquired brain injuries shall be informed of:

- (a) The availability of ABI Waiver Program as an alternative to the nursing facility, nursing facility/brain injury programs;
- (b) The scope of the ABI Waiver Program and the individual's and his informal caregivers' responsibilities if he chooses to enroll (MAP 4096); and
- (c) The services available to assist and prepare him for his re-entry into the community.

To be eligible for participation in the ABI Waiver Program, the individual must meet the level of care criteria for nursing facility services and the following conditions:

- (a) Have a primary diagnosis that indicates an acquired brain injury with structural, non-degenerative brain damage and be medically stable;
- (b) Exhibit cognitive, behavioral, motor or sensory damage with a potential for rehabilitation and retraining;
- (c) Have a rating of at least four (4) on the Rancho Los Amigos Level of Cognitive Function Scale (Refer to Appendix III);
- (d) Is realistically expected, upon discharge from the ABI Waiver Services Program, to remain in the community setting with existing community resources; and
- (e) Be determined that the provision of ABI waiver

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION III - OVERVIEW OF THE ACQUIRED
BRAIN INJURY (ABI) WAIVER PROGRAM

services is cost-effective compared to appropriate nursing facility and nursing facility/brain injury services.

Injuries within the scope of benefits may include:

- (a) Central nervous system injury from a physical trauma;
- (b) Central nervous system damage from anoxia or hypoxic episode; or
- (c) Central nervous system damage from an allergic condition, toxic substance or another acute medical incident.

The following list includes, but is not limited to, conditions which shall not be considered brain injuries requiring specialized rehabilitation under this waiver program:

- (a) Strokes treatable in a nursing facility that provides routine rehabilitation services;
- (b) Spinal cord injuries in which there are no known or obvious injuries to the intracranial central nervous system;
- (c) Progressive dementia and other mentally impairing conditions of a chronic degenerative nature such as senile dementia, organic brain disorders, Alzheimer's Disease, alcoholism or other addictions;
- (d) Depression and psychiatric disorders in which there is no known or obvious central nervous system damage;
- (e) Mental retardation without an etiology to the acquired brain injury;
- (f) Birth defect related disorders; and

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION III - OVERVIEW OF THE ACQUIRED
BRAIN INJURY (ABI) WAIVER PROGRAM

- (g) Conditions which cause the individual to pose a level of dangerous or aggressive behavior which cannot be managed and treated in the community.

The basis of the determination for eligibility in the ABI waiver program is:

- (a) The presenting problem(s);
- (b) The plan of care goals and expected benefits of the admission and the expected outcome of re-entry into the community within a reasonable period of time, taking into consideration an average length of stay of 358 days;
- (c) The services required; and
- (d) The cost-effectiveness as an alternative to nursing facility and nursing facility/brain injury services.

A level of care determination shall be made for all recipients who wish to consider acquired brain injury waiver services and who may be eligible for nursing facility services. In all instances, the Peer Review Organization (PRO) shall make the nursing facility level of care determination in accordance with CFR 440.40 and 440.150.

Those individuals who may be eligible and wish to consider ABI waiver services shall select a participating ABI case management waiver agency. The case management agency shall gather the information necessary for the PRO to determine individual's eligibility for ABI waiver services.

The determination for ABI waiver service eligibility shall be made by the PRO.

For hospital inpatients with a diagnosis of acquired brain

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION III - OVERVIEW OF THE ACQUIRED
BRAIN INJURY (ABI) WAIVER PROGRAM

injury and whose care needs indicate that NF services may be required, hospitals are requested to refer them to an ABI case management agency or the Brain Injury Services Unit, within the Department for Mental Health and Mental Retardation.

It shall be the NF's responsibility to ensure that all recipients with an acquired brain injury are informed of the availability of ABI waiver services as an alternative to institutionalization, prior to admission to the NF.

In accordance with Section 1902 (a) (3) of the Social Security Act, and the administrative hearing process described in 42 CFR Part 431, Subpart E, individuals who have been denied benefits or who have not been given the choice of ABI services as an alternative to NF services shall be granted an opportunity for a fair hearing in accordance with KRS 13B, 907 KAR 1:563.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

SECTION IV - CONDITIONS FOR PARTICIPATION

A. Participation Overview

Services shall be furnished by a Medicaid participating ABI waiver services provider agency. An individual shall not be enrolled with a participating provider agency which cannot provide or arrange for the individual's required services. Contractual arrangements made by a participating provider agency shall be in writing and shall stipulate that payment by the Department shall constitute reimbursement in full and shall relieve the Medicaid Program and the recipient of further liability.

B. Out-of-State Providers

Out-of-state providers with a Kentucky Certificate of Need and certified to provide services to Medicaid Program recipients residing in Kentucky shall complete the same participation agreement forms required for in-state providers.

C. Acquired Brain Injury Waiver Provider Agency Qualifications

All participating acquired brain injury services provider agencies shall:

- (a) Meet the conditions for participation in the Acquired Brain Injury (ABI) Waiver Program;
- (b) Be Medicaid certified;
- (c) Be subject to the financial sanctions as established in 907 KAR 1:671; and
- (d) Have written policies and procedures that comply with the conditions for participation established in this manual.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

- (e) Meet the applicable certification requirements for providing home- and community-based waiver services in accordance with 907 KAR 1:671, 907 KAR 1:672, KRS 205.8477 and 42 CFR 455 Subpart B.
- (f) Be a legally constituted entity in the state of Kentucky, with a constitution and by-laws and shall have documenting evidence of its operating authority; i.e., the administrative framework of the governmental department of which it is a component; a private agency shall have a charter or articles of incorporation, constitution and by-laws.
 - 1. The governing body shall delegate to the Executive Director the authority and responsibility for the management of agency affairs in accordance with written policies and procedures.
 - 2. The Executive Director shall be qualified by training and experience with a minimum of a Bachelor's degree in Administration or human services and a minimum of one year experience working in an organization serving people with disabilities.
 - 3. In accordance with the policies and procedures established by the governing body, the Executive Director shall be responsible to the governing body for the overall operation of the organization, including the control, utilization, and conservation of its physical and financial assets and the recruitment and direction of staff.

D. Ineligibility for ABI Waiver Provider Participation

A provider agency that has been terminated from another Medicaid Program is not eligible for participation in the ABI Waiver Program in accordance with 907 KAR 1:671 and 907 KAR 1:672.

E. Termination of ABI Waiver Provider Agency Participation

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

A provider agency's participation may be terminated by either the provider or the Department for Medicaid Services for cause or without cause in accordance with 907 KAR 1:671 and 907 KAR 1:672.

F. Record Requirements

The participating provider agency shall be required to maintain for each recipient, a clinical record which covers the services provided directly and through arrangements with other agencies. The clinical record shall contain pertinent past and current medical, nursing, social, and other information including the comprehensive assessment and the plan of care.

Staff notes based on the individual's approved plan of care shall be required for each time a service is rendered. In addition, time and attendance logs indicating beginning and ending times each time a service is provided shall be documented including the signature and title of the person providing the service.

These records shall be kept in a central file, one location for each provider number.

All participating provider agencies and their contractors and sub-contractors shall be required to comply with 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Providers shall maintain the records necessary to fully disclose the extent of the service provided. These records shall be maintained for a period of not less than five (5) years from the date of service and for any additional time as may be necessary in the event of an audit exception or other dispute.

Providers shall furnish to the Department or its authorized representative, as requested, information regarding any claims for services provided under the Medicaid Program. Providers shall open records for review or copying by duly authorized representatives of the Cabinet for Health Services or the Health Care Financing Administration (HCFA) for the purpose of the audit

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

of services for which program payment has been made and the monitoring of the health, welfare, and safety of an individual.

G. General Service Provider Qualifications and Requirements

1. An ABI waiver provider agency shall conduct a thorough and complete check on any potential employee. Prior to employing a person to provide ABI waiver services, the ABI waiver provider agency shall check all information supplied on a potential employee's application.
2. As indicated below, all professional and paraprofessional service providers who provide on-going direct services shall not have a criminal record nor a history of perpetrating fraud, abuse, neglect or exploitation.

Criminal records shall include:

- (a) Convictions or pleas of guilty to a felony or misdemeanor offense related to theft, fraud or abuse;
- (b) Abuse or sale of illegal drugs;
- (c) Abuse, neglect or exploitation of a person; or
- (d) A sexual or other violent crime.

Prior to employment, agencies that provide ABI waiver services shall request and receive conviction information, from the Kentucky Justice Cabinet **and** any other appropriate in-state and out-of-state agency, for any potential employee or contractor who shall provide on-going direct services. The request to the Kentucky Justice Cabinet is made using the Request for KSP Convictions Data Only/Employment Form. (Refer to Appendix IX)

3. All professional and paraprofessional direct service staff shall be CPR certified.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

All professional and paraprofessional direct service staff shall be free of communicable diseases and the provider shall present documentation that staff have received tuberculosis screening.

4. Provider Agencies shall conduct periodic and regularly scheduled supervisory visits of all professional and paraprofessional direct service staff at the service site in accordance with their written policies and procedures. Additional supervisory visits shall be conducted as necessary in order to ensure that high quality, appropriate services are provided to ABI waiver individuals.
5. The sixteen (16) hour orientation and training requirement as specified in the personnel qualifications of each service shall be completed prior to the provision of any direct service.

H. Licensed, Certified or Degreed Professional Staff
Qualifications

1. Unless otherwise specified, to be qualified to provide services under the ABI Waiver Program all licensed, certified or degreed professional staff shall, within the prior (5) years, have two thousand (2000) hours of experience in serving persons with a primary diagnosis of brain injury. This experience shall be in:
 - (a) Primary, direct assessment or treatment of individuals with brain injury; or
 - (b) Administrative responsibilities for an organized brain injury program.
2. Successful completion of a sixteen (16) hour approved brain injury orientation and training program for professional staff may be substituted for the required experience. All professional staff shall be required to complete six (6) hours

SECTION IV - CONDITIONS FOR PARTICIPATION

of continuing education in brain injury annually.

I. Crisis Prevention and Response Plan

1. A Crisis Prevention and Response Plan which addresses any potential crisis situation which may impact on the health, welfare, or safety of a participant shall be developed by the case manager in cooperation with residential and other service providers within thirty (30) days of admission.
2. The case manager shall disseminate the Crisis Prevention and Response Plan to all program area sites where a participant will be receiving supports. The plan shall be easily accessed and available to all staff working with a participant.

J. Incident Reporting

- (1) An incident shall be documented on the incident report form contained in Appendix X.
- (2) Following are incident classifications and reporting requirements:
 - (a) A class I incident shall:
 1. Be minor in nature;
 2. Not require an investigation by the provider agency;
 3. Be reported to the case manager within twenty-four (24) hours; and
 4. Be retained on file at the provider, as well as case management, agency;
 - (b) A class II incident shall:
 1. Be serious in nature including:
 - a. Personal injury or illness of an ABI recipient or ABI service provider staff person which requires emergency treatment or admission to a hospital or other treatment facility;
 - b. A medication error requiring medical attention;
 - c. A criminal act; or
 - d. Significant property damage;
 2. Require an investigation initiated by the provider agency within twenty-four (24) hours of discovery and shall involve the case manager;

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

3. Be reported to the following by the provider agency:
 - a. The case manager within twenty-four (24) hours of discovery;
 - b. The guardian within twenty-four (24) hours of discovery, followed by a complete written report within ten (10) calendars days; and
 - c. The Department for Mental Health and Mental Retardation's (DMHMR's), Division of Mental Health, Brain Injury Services Unit, within twenty-four (24) hours of discovery, followed by a complete written report within ten (10) calendar days;
- (c) A class III incident shall:
 1. Be grave in nature including:
 - a. Death;
 - b. An event made controversial due to media exposure, even if unrelated to a specific incident; or
 - c. Suspected or actual abuse, neglect, or exploitation;
 2. Be immediately investigated by the provider agency, and the investigation shall involve the case manager; and
 3. Be reported to the following by the provider agency:
 - a. The case manager within eight (8) hours of discovery,
 - b. The Cabinet for Health Services, Department for Community Based Services (DCBS) within eight (8) hours of discovery;
 - c. The guardian within eight (8) hours of discovery, followed by a complete written report within seven (7) calendar days;
 - d. The Department for Mental Health and Mental Retardation's (DMHMR's), Division of Mental Health, Brain Injury Services Unit within eight (8) hours of discovery, followed by a complete written report within seven (7) calendar days of discovery.

K. Behavioral Programming and Support

1. The provider shall have written policies and procedures which define the behavior support techniques and procedures which may be used, including the hierarchy of interventions ranging from least to most restrictive.
2. The provider's written policy, procedures, and records shall emphasize and reflect the use of positive approaches and behavioral supports.

SECTION IV - CONDITIONS FOR PARTICIPATION

3. The use of the following shall be prohibited:
 - a. Corporal punishment: the application of painful stimuli to the body as a penalty for certain behavior, includes, but is not limited to, forced physical activity or exercise, hitting, pinching, the use of electrical shock or other infliction of pain, whether or not applied as a part of a systematic behavior support program;
 - b. Seclusion: the placement of an individual alone or in a room or other area from which exit is prevented. This does not include placement in an appropriately equipped, safe time-out area for brief, programmed time segments, as part of a behavior intervention program that meets all applicable standards and has been approved by the individual, the individual's guardian, the behavior intervention committee, and the human rights committee
 - c. Verbal abuse: screaming, swearing, name-calling, or other verbal activity that may cause damage to an individual's self respect, or may reduce the individual's dignity when overheard or observed by others;
 - d. Any procedure which denies requisite sleep, shelter, bedding, food, drink, or use of bathroom facilities.
4. Highly restrictive procedures (i.e., any enclosed space used for time-out, physical restraints and drugs for behavioral support) are defined as follows:
 - a. Any enclosed area used for time-out is an area in which the individual is placed contingent upon the exhibition of a maladaptive behavior, in which reinforcement is not available, and from which exit is denied until appropriate until a predetermined, approved criterion is met. This may only be consistently used when the individual's behavior is known to respond to the time-out and that the procedure is rapidly reducing the behavior addressed.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

- b. Physical restraint refers to manual methods or mechanical devices that are intended to restrict the movement or normal functioning of a portion of the individual's body. Examples of manual methods include "therapeutic" or "basket" holds, and prone or supine containment. Examples of mechanical devices include arm splints, posey mitts, and straight jackets. Excluded are physical guidance and prompting techniques of brief duration and mechanical supports to position or support the individual; or
 - c. Drugs to support behavior refers to medication prescribed and administered for the purpose of modifying the maladaptive behavior of an individual other than those prescribed for mental illness. Examples include antidepressants, stimulants, and major and minor tranquilizers.
5. Highly restrictive procedures shall be used only when the following conditions are met:
- a. The individual's team, including a behavior specialist, the individual, their legal representative or advocate as appropriate, and the Human Rights Committee concur that the use of highly restrictive intervention is required and that to allow the persistent and intractable behavior to continue would cause harm to the individual or others.
 - b. The team shall weigh the risks of the behavior against the risks of the intervention and there shall be documentation that systematic efforts to replace the behavior with an adaptive skill have been included as a part of the behavior intervention plan.
 - c. There shall be documentation that less restrictive procedures have been considered and found to be ineffective. There also shall be documented informed consent from the individual or his legal representative;
 - d. An individualized written plan for behavioral support, based on a functional analysis of the behavior, has been developed by the individual's Interdisciplinary Team and approved by the Human Right's Committee and Behavior Intervention

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

Committee prior to implementation. The plan must be reviewed at least every 6 months by those committees.

- e. When drugs, which are not necessary for treatment of a mental illness are used to manage maladaptive behavior, there shall be a plan for drug reduction or documentation that a drug reduction plan has been implemented and proven ineffective. The individual's physician shall approve the drug reduction plan or provide documentation that the medication cannot be reduced.
- f. In case of emergency, physical restraints and removal from the environment may be used, but only to prevent harm or major damage to the environment. These may be used no more than three (3) times over a six (6) month period without the team meeting to review or perform a functional analysis and develop an effective behavior plan.

L. Safety

- 1. The provider shall ensure that an individual served is safe.
- 2. The provider shall:
 - a. Follow written policies and procedures which address maintenance of sanitary conditions for individuals;
 - b. Have and follow a plan for meeting emergencies and disasters such as fire, severe weather and missing persons;
 - c. Include in the emergency plan, instructions for notification procedures and the use of alarm and signal systems to alert an individual who cannot hear;
 - d. Include in the plan that evacuation drills be conducted and documented at least quarterly and scheduled at different times when an individual is asleep;
 - e. Evaluate the results of the drills and change the plan to accommodate an individual who is unable to achieve the plan

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

schedule;

- f. Assure that the nutritional needs of an individual are met in accordance with the current recommended dietary allowance of Food and Nutrition Board of the National Research Council or as otherwise specified by a physician;
- g. Assure that all staff administering medication have specific training and documented competency demonstrated on cause and effect of that medication and proper administration and storage;
- h. Document all medication that is administered, including over-the-counter drugs, on a medication log, with the date, time and initials of the person who administered the medication (this includes medications that are self-administered);
- i. Assure that all medications which accompany an individual to a program site other than his living arrangement are carried in a proper container labeled with medication and dosage. (Note: At the time of filling the prescription, the provider may request a duplicate label and container);
- j. Assure that when medication is discontinued, the date of discontinuance and the name of the attending physician are written on the medication administration form and that section is lined through;
- k. Follow written policies and procedures for proper disposal of medications; and
- l. Assure that all medications are kept in a locked container. This includes over-the-counter drugs and vitamins as well as prescription drugs.
- m. The residence operated by the provider shall:
 - 1. Be equipped with smoke detectors in working order, placed

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

in strategic locations.

2. Be equipped with at least two fire extinguishers (one which is capable of extinguishing a grease fire) that are at or above the rating of the 1A10BC type placed in strategic locations;
3. Have separate sleeping rooms for persons of the opposite sex (except spouses) or for persons placed in undue physical danger due to the relative size and strength of another individual;
4. Have a separate bed for each individual which is equipped with substantial springs, a clean comfortable mattress, and clean bed- linens (individuals who are married may choose to share a bed).
5. The water temperature from all faucets will not exceed 110 degrees Fahrenheit.

M. Provider Agency Qualifications, Personnel Qualifications, and Service Definition

1. Case Management

(a) Provider Agency Qualifications

A participating case management (CM) agency shall be a legally constituted entity in the Commonwealth of Kentucky and shall have documenting evidence of its operating authority; i.e., the administrative framework of the governmental department of which it is a component; a private agency shall have a charter or articles of incorporation, constitution and by-laws. The agency shall have written policies and procedures that comply with the conditions for participation in the ABI Waiver Program as established in this Manual.

SECTION IV - CONDITIONS FOR PARTICIPATION

All participating case management agencies shall meet all applicable Federal, State and local rules, laws, regulations, requirements, and shall be Medicaid-certified for participation in the ABI Waiver Program.

All agencies that provide case management services shall be under the supervision of a certified case manager (CCM), certified disability management specialist (CDMS), certified rehabilitation registered nurse (CRRN), or a certified life care planner. The CCM, CDMS, CRRN, or certified life care planner shall be an employee of the agency or under contract.

Compliance with the conditions for participation for case management services shall be monitored and verified by annual on-site surveys.

(b) Personnel Qualifications

Case management waiver services shall be provided by licensed personnel or by persons with at least a Bachelor's degree in human services. These individuals may include:

- (1) Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) licensed in the State of Kentucky by the Kentucky Board of Nursing;
- (2) Persons with a Bachelor's or Master's degree who meet all requirements applicable to their particular field.

Persons referenced in item (2) above may include individuals with degrees in psychology, sociology, social work, special education, rehabilitation counseling, occupation therapy, physical therapy and

SECTION IV - CONDITIONS FOR PARTICIPATION

the case manager shall include a preliminary transition plan and the anticipated outcome of services. The purpose is to provide necessary information to consider in planning for re-entry to the community with the availability of services in the community and to establish criteria for discharge from the ABI Waiver program.

The Transition Plan shall include, at a minimum:

- (a) The skills or supports the individual will have gained from ABI Waiver services upon transition from the program;
- (b) A listing of the on-going formal and in-formal community supports the individual will have available upon transition from the ABI Waiver Program; and
- (c) A listing of additional resources that will be needed once ABI Waiver services end.

Case management services include:

- (1) On-going monitoring;
- (2) Review of the provision of services in the individual's plan of care as dictated by the individual's health status and care needs; and
- (3) Submission of an updated plan of care to the Department or its designated agent at least every six (6) months.

The case manager shall have a total caseload of no more than forty (40) individuals, irrespective of the payor source, and shall not be a provider of other

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

direct services. The case manager shall be an employee of a participating ABI waiver program agency. The participating ABI waiver program agency shall be responsible for supervising case managers, assuring twenty-four (24) hour availability of necessary services and ensuring that the individual's health, welfare and safety needs are met.

Making use of functional assessments, the case manager shall be responsible for:

- (1) The overall development of the individual's plan of care in cooperation with the interdisciplinary team, the individual, family members, his legal representative and other persons selected by the individual;
- (2) Furnishing the individual and his or her legal representative or advocate, as appropriate, written information describing the services of all available providers in the individual's service area and ensuring that all questions related to service options are addressed;
- (3) Maintaining written documentation, signed by the individual or legal representative, of any change to the selection of providers and of the reason for the change;
- (4) Ensuring that the individual exercises his freedom of choice;
- (5) Maintaining proper documentation and ensuring that interdisciplinary team members receive copies of all relevant documentation; and
- (6) Meeting with the individual face-to-face every

SECTION IV - CONDITIONS FOR PARTICIPATION

two (2) weeks. Face-to-face meetings shall include at least one (1) visit each quarter in the individual's own home. For individuals who do not live with family or in their own home, monthly visits shall be required with the individual in his place of residence;

(7) Providing monthly caseload reports to the department; and

(8) The individual's transition plan.

2. Personal Care (PC) Services

(a) Provider Agency Qualifications

Participating provider agencies for personal care services shall be licensed and Medicaid-certified.

(b) Personnel Qualifications

Persons who provide personal care services shall:

(1) Have a high school diploma or GED;

(2) Be CPR certified;

(3) Be free from communicable diseases;

(4) Have no criminal record as defined in Subsection G of this Section;

(5) Have no history of perpetrating fraud, abuse, neglect or exploitation; and

(6) Have successfully completed a formalized training program such as the Nursing Facility Nurse Aide Training or Home Health Aide

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

Training Program or have experience of at least two years, full-time, in the provision of services in home health, long term care, acute care hospital or rehabilitation hospital.

The personal care provider agency shall check the Nurse Aide Abuse and Neglect Registry maintained by the Office of the Inspector General, Division of Licensing and Regulation, and any other applicable registry to determine if the individual has any history of perpetrating abuse or neglect. **NOTE:** Only certified nurse aides employed or previously employed in nursing facilities may be on the Nurse Aide Abuse and Neglect Registry.

The personal care provider agency shall ensure that the personal care provider is properly trained and capable of meeting the needs of the individual.

In addition, prior to the provision of direct services, personal care providers shall successfully complete a sixteen (16) hour brain injury orientation and training curriculum approved by the Kentucky Medicaid Program. They shall also complete six (6) hours of continuing education in brain injury annually.

(c) Service Definition

This service shall include the retraining of the individual by the personal care provider in the performance of the individual's activities of daily living. The purpose is to further assist the individual to function as independently as possible by using repetitive, consistent and on-going instruction and guidance. PC services which are essential to the health and welfare of the individual may include assistance and instruction with:

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

- (1) Eating, bathing, dressing, personal hygiene, and activities of daily living;
- (2) Preparation of meals, but not to include the cost of the meals themselves; and
- (3) Housekeeping chores such as bed-making, dusting and vacuuming.

3. Respite Care

(a) Provider Agency Qualifications

Participating provider agencies for respite care shall be Medicaid-certified.

(b) Personnel Qualifications

Persons who provide respite care shall be required to:

- (1) Have a high school diploma or GED;
- (2) Be CPR certified;
- (3) Be free from communicable diseases;
- (4) Have no criminal record as defined in Subsection G of this Section;
- (5) Have no history of perpetrating fraud, abuse, neglect or exploitation; and
- (6) Have successfully completed a formalized training program, such as the Nursing Facility Nurse Aide Training or Home Health Aide Training Program, or have experience of at least two (2) years, full-time, in the provision of services in home health, long term care, acute

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

care hospital or rehabilitation hospital.

The provider agency shall check the Nurse Aide Abuse and Neglect Registry maintained by the Office of the Inspector General, Division of Licensing and Regulation and any other applicable registry to determine if the individual has any history of perpetrating abuse or neglect. **NOTE:** Only certified nurse aides employed or previously employed in nursing facilities may be on the Nurse Aide Abuse and Neglect Registry.

The provider agency shall ensure that the respite care provider is properly trained and capable of meeting the needs of the individual.

In addition, prior to the provision of direct services, respite care providers shall successfully complete a sixteen (16) hour brain injury orientation and training curriculum approved by the Kentucky Medicaid Program. They shall also complete six (6) hours of continuing education in brain injury annually.

(c) Service Definition

Respite care is a service provided to individuals unable to care for themselves. It is provided on a short-term basis because of the absence or need for relief of those persons normally providing on-going care.

Respite care may be provided in the individual's own home; in a residence or setting approved by the provider agency for example, in the respite care provider's home; or in a nursing facility. Payment for respite care in other than a nursing facility shall not include the cost of room and board.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

Respite care shall be available only to individuals living at home with family, or with other unpaid caregivers who need relief. Respite care shall be limited to no more than 168 hours in a six (6) month period. An exception to this limitation may be granted only when the primary caregiver's ability to care for the individual is compromised by death in the family, serious illness or hospitalization.

4. Companion Services

(a) Provider Agency Qualifications

Participating provider agencies for companion services shall be Medicaid-certified.

(b) Personnel Qualifications

Persons who provide companion services shall be required to:

- (1) Have a high school diploma or GED;
- (2) Be CPR certified;
- (3) Be free from communicable diseases;
- (4) Have no criminal record as defined in Subsection G of this Section;
- (5) Have no history of perpetrating fraud, abuse, neglect or exploitation; and
- (6) Have successfully completed a formalized training program, such as the Nursing Facility Nurse Aide Training or Home Health Aide Training Program, or have experience of at

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

least two years, full-time, in the provision of home health, long term care, acute care hospital or rehabilitation hospital.

The provider agency shall check the Nurse Aide Abuse and Neglect Registry maintained by the Office of the Inspector General, Division of Licensing and Regulation, **and** any other applicable registry to determine if the individual has any history of perpetrating abuse or neglect. **NOTE:** Only certified nurse aides employed or previously employed in nursing facilities may be on the Nurse Aide Abuse and Neglect Registry.

The provider agency shall ensure that the companion service provider is properly trained and capable of meeting the needs of the individual being served.

In addition, prior to the provision of direct services, companion service providers shall successfully complete a sixteen (16) hour brain injury orientation and training curriculum approved by the Kentucky Medicaid Program. They shall also complete six (6) hours of continuing education in brain injury annually.

(c) Service Definition

Companion services include non-medical services, supervision and socialization provided to a functionally impaired adult. A companion may assist the individual with such tasks as meal preparation, laundry and shopping, but does not perform these activities as discrete services. The provision of companion services does not usually entail hands-on medical care. A companion may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. These services are provided in accordance with a therapeutic goal in the

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

approved plan of care, and are not merely diversional in nature. They are necessary to prevent institutionalization and assist the individual in his rehabilitation and re-entry into the community.

Providers of companion services shall also, when necessary, accompany and assist the individual when utilizing assisted transportation services.

5. Structured Day Program Services

(a) Provider Agency Qualifications

Participating provider agencies of Structured Day Program (SDP) services shall be licensed as adult day health care centers, outpatient rehabilitation facilities or shall be Medicaid Certified and meet all additional requirements applicable to the ABI Waiver Program as specified in this Manual.

Compliance with Medicaid SDP Conditions for Participation shall be monitored by annual on-site reviews. The individual's outcomes in response to his individualized service plans in the approved plan of care shall be utilized as one aspect of the assessment of the program compliance with conditions for participation in the Medicaid ABI Waiver Program.

The staffing ratio for the Structured Day Program shall not exceed five (5) individuals to one(1) staff person.

(b) Personnel Qualifications

Persons who provide Structured Day Program services shall be required to:

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

- (1) Have a high school diploma or GED;
- (2) Be CPR certified;
- (3) Be free from communicable diseases;
- (4) Have no past criminal record as defined in Subsection G of this Section; and
- (5) Have no history of perpetrating fraud, abuse, neglect or exploitation.

The provider agency shall check the Nurse Aide Abuse and Neglect Registry maintained by the Office of the Inspector General, Division of Licensing and Regulation, and any other applicable registry to determine if the individual has any history of perpetrating abuse or neglect. **NOTE:** Only certified nurse aides employed or previously employed in nursing facilities may be on the Nurse Aide Abuse and Neglect Registry.

The provider agency shall ensure that all staff are properly trained and capable of meeting the needs of the individuals being served.

For any service provided through contractual arrangement, the SDP provider agency shall ensure that the contractor meets all direct service provider requirements.

Prior to the provision of direct services, staff providing or supervising Structured Day Program services for ABI waiver individuals shall successfully complete the sixteen (16) hour brain injury orientation and training curriculum approved by the Kentucky Medicaid Program. They shall also complete six (6) hours of continuing education in brain injury annually.

SECTION IV - CONDITIONS FOR PARTICIPATION

(c) Service Definition

The Structured Day Program is the provision of services directed at the development and improvement of community living skills. The service takes place in a non-residential setting separate from the home in which the individual lives. This service includes supervision and specific training to allow the individual to achieve his maximum potential in order to reintegrate into the community. SDP services may include social skills training, sensory/motor development, reduction/elimination of maladaptive behavior and prevocational services. Services aimed at preparing the individual for re-entry into the community include teaching concepts and skills for independence such as:

- (1) Following directions;
- (2) Attendance;
- (3) Task completion;
- (4) Problem solving;
- (5) Safety;
- (6) Social appropriateness; and
- (7) Money management.

Structured Day Program services shall be coordinated with any physical, occupational, speech or other rehabilitation therapy in the approved plan of care. This service shall be necessary to prevent institutionalization and to assist the individual in his rehabilitation and re-entry into the community.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

As with all services provided under the ABI Waiver Program, the focus of the Structured Day Program shall be to rehabilitate, retrain and reintegrate the individual into the community.

The Structured Day Program shall provide the individual with an organized framework within which to function in his daily activities. The Structured Day Program shall identify the portions of the following continuum it will address for each individual:

- (1) Personal and living independence;
- (2) Work adjustment and productivity; and
- (3) Psychological and social adjustment.

The Structured Day Program shall demonstrate the implementation of brain-injury-specific approaches that meet the needs of the individual. The program shall be directed toward the development of the individual's optimal level of functioning and community reintegration.

The day program service plan shall be developed in accordance with the individual's overall plan of care and shall reflect the recommendations of the ABI service interdisciplinary team. The case manager shall coordinate with the day program staff on the behalf of the interdisciplinary team. The Structured Day Program services shall be appropriate to the individual's age, level of cognitive and behavioral function and interest. Consideration shall be given to the individual's age, his interest prior to and since his injury, and aptitudes prior to and since his injury. The services shall include one-on-one attention as indicated and necessary.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

Each individual's plan of care for day program services shall be an individualized, progressive, intense program with short-term goals and provide for careful, frequent assessments of the individual's progress and revisions or updates as indicated and necessary.

The program's ongoing activities for the individuals being served shall be purposeful and carry out the goals established by therapists and other professionals in the individual's overall plan of care.

Each Structured Day Program shall meet the minimum staffing ratio established in Subsection M.5(a) of this Section in order to provide the necessary rehabilitation, retraining and supervision of the individual.

As part of the Structured Day Program, prevocational services, if needed, shall be provided in accordance with the individual's approved plan of care.

Supported employment services may be provided in lieu of or in combination with the Structured Day Program. Supported employment is defined in Subsection M.6 of this Section.

Day programming, in any combination i.e., structured day or supported employment services shall not exceed forty (40) hours each week.

The time spent in another service shall be clearly documented and separated from the time spent in the Structured Day Program and billed as a separate service. For example: If the individual attends the Structured Day Program from 10:00 a.m. until 3:00 p.m. and receives speech therapy from 1:00 pm to

SECTION IV - CONDITIONS FOR PARTICIPATION

2:00 pm; four (4) hours shall be billed to the Structured Day Program and one (1) hour shall be billed to speech therapy.

6. Supported Employment Services

(a) Provider Agency Qualifications

Participating provider agencies of supported employment services shall be licensed as adult day health care centers, or outpatient rehabilitation facilities or shall be Medicaid certified.

(b) Personnel Qualifications

The minimum service provider qualifications are the same as those set forth in Subsection M.5. of this Section.

In addition, persons with a Bachelor's or Master's degree in rehabilitation counseling may also provide supported employment services.

(c) Service Definition

Supported Employment Services shall be:

(1) Paid employment for persons who:

- a. Are unlikely to obtain competitive employment at or above minimum wage; and
- b. Need intensive ongoing support to perform in a work setting because of a disability.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

- (2) Conducted in a variety of settings, particularly in work sites in which persons without disabilities are employed.
- (3) Activities needed to sustain paid work by an individual receiving waiver services, including supervision and training; and
- (4) Paid when not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. For an individual receiving this service, documentation shall be maintained in his record that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

When supported employment services are provided at a work site in which persons without disabilities are employed, payment shall be made only for the supervision and training required as the result of the individual's disabilities, and shall not include payment for the supervisory activities rendered as a normal part of the work setting. This service shall be necessary to prevent institutionalization and to assist the individual in his rehabilitation and re-entry into the community.

Supported employment services shall be provided in lieu of or in combination with the Structured Day Program. One-on-one job coaching shall be provided at the job site either by Day Program staff or by contractual arrangements made by the day program in cooperation with the case manager.

7. Behavior Programming

- (a) Provider Agency Qualifications

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

Participating provider agencies for behavior programming shall be Medicaid-certified.

(b) Personnel Qualifications

A behavior specialist who provides behavior programming services shall be a:

- (1) Licensed psychologist;
- (2) Certified psychologist with autonomous functioning;
- (3) Psychological associate or certified psychologist;
- (4) Psychiatrist;
- (5) Licensed clinical social worker; or
- (6) Clinical nurse specialist with a Master's degree in psychiatric nursing or rehabilitation nursing or an Advanced Registered Nurse Practitioner (ARNP) **AND**

shall have a minimum of one year of experience as a behavior specialist or shall provide documentation of coursework in the principles and techniques of learning and behavior.

Unless otherwise specified, to be qualified to provide services under the ABI Waiver Program, all licensed, certified or degreed professional staff shall, within the prior five (5) years, have two thousand (2000) hours of experience in serving persons with a primary diagnosis of acquired brain injury. This experience shall be in: Primary, direct assessment or treatment of individuals with acquired brain injuries, or

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

administrative responsibilities for an organized brain injury program.

Successful completion of a sixteen (16) hour approved brain injury orientation and training program for professional staff may be substituted for the required experience in serving persons with a primary diagnosis of acquired brain injury.

All professional staff shall be required to complete six (6) hours of continuing education in brain injury annually.

(c) Service Definition

Behavior Programming entails individually designed strategies to decrease the individual's severe maladaptive behaviors which have interfered with his ability to remain in the community. It includes:

- (1) The use of a planned systematic application of techniques and methods to influence or change a behavior in a desired way;
- (2) The belief that behavior is learned and maintained because of its consequences;
- (3) Techniques to increase acceptable behavior and decrease maladaptive behavior;
- (4) Monitoring of the individual's progress and development of any needed revisions to the plan, to be accomplished through an analysis of data about the frequency, intensity, and duration of the behavior and observations of staff working with the individual; Addressing maladaptive behaviors which:
 - (a) Present a risk of or result in harm to the person or others;

SECTION IV - CONDITIONS FOR PARTICIPATION

- (b) Result in property damage;
 - (c) Interfere on an on-going basis with the delivery of services identified in the plan of care;
 - (d) Interfere with the individual's acceptance and reintegration into the community ;or
 - (e) Are illegal
- (5) Development of a structured behavioral intervention plan;
 - (6) Implementation of the plan;
 - (7) On-going training and supervision to caregivers and direct contact and service staff; and
 - (8) Periodic reassessment of the plan.
 - (9) An approved behavior intervention plan shall be carried out by direct contact and service staff in all relevant environments and activities, under the supervision of the Behavior Specialist. Behavior programming may be provided in the individual's home or in the community.

Behavioral learning principles and techniques are applied to:

Promote acquisition and mastery of adaptive behavioral patterns; and To reduce or eliminate maladaptive behavioral patterns.

A functional analysis shall be completed by a qualified professional behavioral specialist. The functional analysis shall include:

- (1) The target behavior;
- (2) Frequency, intensity and severity of the behavior;
- (3) Antecedents and consequences of the behavior;

SECTION IV - CONDITIONS FOR PARTICIPATION

- (4) An analysis of the potential communicative intent of the behavior;
- (5) The history of reinforcement for the behavior;
- (6) Environments where the behavior does and does not occur;
- (7) The social context;
- (8) Hypotheses regarding the motivation, purpose and factors that maintain the behavior;
- (9) Medical, physical, cognitive and emotional status of the individual
- (10) Knowledge and reaction of significant others involved;
- (11) Day to day changes in personal functioning of the individual
- (12) A history of other approaches which have proven unsuccessful in changing the behavior
- (13) A justification for changing the target behavior

Upon completion of the functional analysis, the behavior specialist may develop a Behavior Intervention Plan in cooperation with the individual. The Behavior Intervention plan shall include, at a minimum:

- (1) The target behaviors to be changed;
- (2) Procedures for generalizing and maintaining goals in the individual's natural environment;
- (3) A history of other approaches which have proven unsuccessful in changing the behavior;
- (4) A justification for changing the target behavior; and

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

- (5) Time frames for review, revision and completion
- (6) An indication of the frequency, intensity or duration of the target behaviors;
- (7) A justification for intervention;
- (8) The replacement behaviors to be taught and specification of the methods for teaching them;
- (9) The specific methods to be employed to change the target behaviors;
- (10) The methods of data collection and evaluation of the effectiveness of the intervention;
- (11) The specific reinforcers to be used;
- (12) An indication of the rights being restricted;
- (13) An indication of the risks of intervention and the risks of the behavior;
- (14) Documentation of the informed consent of the individual and his legal representative; and
- (15) Documentation of approval by the Behavior Intervention Committee and the Human Rights Committee when restrictive procedures are used.

Upon completion of the functional analysis and the development of an approved comprehensive Behavior Intervention Plan and its implementation, the plan shall be monitored on an on-going basis by the Behavior Specialist for successful outcome.

All Behavior Intervention Plans shall incorporate the least restrictive, least aversive and least intrusive procedures. The dignity and rights of the individual shall always be protected

SECTION IV - CONDITIONS FOR PARTICIPATION

Individuals who are suicidal, or homicidal or who are acutely psychotic will require other forms of treatment and would not meet the level of care criteria to receive services under the ABI waiver.

Behavior programming services are necessary to avoid institutionalization and to assist the individual in his rehabilitation and re-entry into the community.

8. Counseling

(a) Provider Agency Qualifications

Participating provider agencies for counseling services shall be Medicaid certified.

(b) Personnel Qualifications

Providers of counseling shall be a:

- (1) Psychiatrist;
- (2) Licensed psychologist;
- (3) Certified psychologist with autonomous functioning;
- (4) Psychological associate or certified psychologist;
- (5) Licensed clinical social worker;
- (6) Clinical nurse specialist with a Master's degree in psychiatric nursing or an Advanced Registered Nurse Practitioner (ARNP); or
- (7) Certified alcohol and drug counselor.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

(c) Service Definition

Counseling services under the ABI Waiver Program are designed to help the individual to resolve personal issues or interpersonal problems resulting from the acquired brain injury. Counseling, as an adjunct to behavioral programming may be provided in severe cases, and may include services for substance abuse. If counseling is provided to members of the individual's family, it must be to assist the family in implementing the individual's approved plan of care and for the direct benefit of the individual. Group therapy may be provided if included as a part of the individual's approved plan of care. This service shall be necessary to prevent institutionalization and assist the individual in his rehabilitation and re-entry into the community. Group therapy is a therapeutic intervention provided to a recipient in a group not to exceed eight participants that focuses on subjects relevant to all participants for one or more of the following reasons:

- a. Providing substance abuse or chemical dependency treatment;
- b. Building and maintaining healthy relations;
- c. Developing social skills;
- d. Developing skills to cope with and adjust to a brain injury, including the use of cognitive remediation strategies such as the development of compensatory memory and problem solving strategies, and the management of impulsivity; and
- e. Increasing knowledge and awareness of the effects of the acquired brain injury upon participants'

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

functioning and social interactions.

Group therapy is distinct from structured day program services which offer group activities in a rehabilitative environment that focus on the development and improvement of community living skills, personal and living independence, work adjustment and productivity, and psychological and social adjustment.

Group therapy shall not include physical exercise, recreational, educational, or social activities and shall not be merely diversional in nature.

Group therapy usually occurs for a limited time period, not exceeding ninety (90) minutes and usually occurs not more than once weekly. Group therapy may occur in conjunction with individual counseling. When a recipient participates in both group therapy and individual counseling, the individual counseling usually occurs once weekly for a period not exceeding sixty (60) minutes.

Group therapy may be provided if included as part of the individual's approved plan of care and shall be provided in accordance with a therapeutic goal in the approved plan of care. This service shall be necessary to prevent institutionalization and assist the individual in his rehabilitation and re-entry into the community.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

9. **Occupational Therapy, Speech Hearing and
Language Services**

(a) **Provider Agency Qualifications**
Participating provider agencies shall be Medicaid-certified.

(b) **Personnel Qualifications**

Providers of Occupational Therapy and Speech, Hearing and Language services shall meet all applicable State licensure and certification requirements and be employed by or under contract with a participating ABI waiver provider agency.

(c) **Service Definition**

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

These services shall be provided under the approved Medicaid State Plan. ABI Waiver Program coverage shall be available only for services over and above the Medicaid State Plan limitations in order to provide the services necessary to prevent institutionalization and assist the individual in his rehabilitation and re-entry into the community.

10. Specialized Medical Equipment and Supplies

(a) Provider Agency Qualifications

When prior authorized and included in the approved plan of care, the case management agency shall arrange for and obtain specialized medical equipment and supplies from Medicaid-certified pharmacies and medical suppliers that are certified for participation in the Federal Medicare and Kentucky's Medicaid Programs. (The MAP-95 form is used to request prior authorization of this services.)

(b) Coverage Definition

Medicaid reimbursement under the Acquired Brain Injury Waiver Program shall be limited to specialized medical equipment and supplies. These services shall be preauthorized by the Department for Medicaid Services or its designated agent. Preauthorization shall be based on the medical necessity and the intrinsic essentialness of the equipment and supplies to the rehabilitation and retraining of the individual in accordance with the individual's plan of care.

SECTION IV - CONDITIONS FOR PARTICIPATION

Life support equipment, ancillary supplies and related equipment shall not be included in ABI waiver service coverage. Individual's dependent upon life support equipment, ancillary supplies and related equipment shall not be considered medically ready to successfully participate in the ABI Waiver.

The equipment and medical supplies shall be specified in the individual's approved plan of care. Coverage under the ABI Waiver Program shall be limited to items over and above the coverage available under the approved Medicaid State Plan. All items shall meet applicable standards of manufacture, design and installation. These items shall be necessary to prevent institutionalization and to assist the individual in his rehabilitation and re-entry into the community.

Items which are not medically necessary or of direct medical or remedial benefit to the recipient shall be excluded from coverage.

11. Environmental Modifications

(a) Provider Qualifications

Environmental modifications shall be provided in accordance with applicable state and local building codes.

(b) Personnel Qualifications

When prior authorized and included in the plan of care, the case management agency shall arrange for environmental modifications to be made by qualified contractors. (The MAP-95

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

form is used to request prior authorization of this service.)

Contractors shall meet all state and local law requirements.

Plumbers shall meet all requirements set forth in KRS Chapter 318 and 815 KAR 20:030.

Electricians shall meet all requirements set forth in KRS Chapter 227 and 815 KAR 35:015.

(c) Service Coverage Definition

Environmental modification coverage shall be limited to those physical adaptations to the individual's home, specified in his approved plan of care, which:

- (1) Are necessary to ensure his health, welfare, and safety;
- (2) Enable him to function with greater independence in his home without which he would require institutionalization; or
- (3) Are necessary to accommodate the medical equipment and supplies required for his welfare.

Vehicle modifications and electronic monitoring systems shall not be covered services under the ABI Waiver Program.

Medicaid reimbursement for environmental modifications shall be no more than \$1000 per

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

six month period per individual.

12. Community Residential Services

(a) Provider Agency Qualifications

Participating provider agencies for community residential services (CRS) shall be Medicaid-certified. Compliance with the requirements for the provision of CRS shall be monitored by the Department for Medicaid Services or its designated agent by annual on-site surveys.

(b) Personnel Qualifications

Persons who provide community residential services shall, as a minimum:

- (1) Be required to have a high school diploma or GED;
- (2) Be CPR certified;
- (3) Be free from communicable diseases;
- (4) Have no past criminal record as defined in Subsection G of this Section;
- (5) Have no history of perpetrating fraud, abuse, neglect or exploitation; and
- (6) Have successfully completed a formalized training program, such as the Nursing Facility Nurse Aide Training or Home Health Aide Training Program or experience of at least two (2) years, full-time, in home health, long term care, acute care hospital or rehabilitation hospital.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

The employer agency shall check the Nurse Aide Abuse and Neglect Registry maintained by the Office of the Inspector General, Division of Licensing and Regulation **and** any other applicable registry to determine if the individual has any history of perpetrating abuse or neglect. **NOTE:** Only certified nurse aides employed or previously employed in nursing facilities may be on the Nurse Aide Abuse and Neglect Registry.

The provider agency shall ensure that the community residential services provider is properly trained and capable of meeting the needs of the individual.

In addition, CRS providers shall successfully complete the sixteen (16) hour brain injury orientation and training curriculum approved by the Kentucky Medicaid Program. They shall also complete six (6) hours of continuing education in brain injury annually.

(c) Service Definition

Services which consist of up to 24-hour supervision and oversight, supportive services training in activities of daily living, social skills, and home management tasks provided to residents of a staffed residence or group home.

Supportive services include socialization (part of a plan of care, not diversional or recreational), training individuals to set up meetings and appointments, and providing transportation (when provided by the residential facility only).

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

The CRS provider shall provide assistance and training with personal and home management tasks when the individual is not yet able to perform them independently, including:

- (1) Reminding residents to take medications or perform exercises;
- (2) Household chores when residents' care requires the prevention of exposure to infectious disease or containment of infectious disease;
- (3) Assisting with dressing, oral hygiene, hair care, grooming and bathing;
- (4) Housekeeping;
- (5) Laundry; and
- (6) Shopping

Community residential services shall include the retraining of the individual in the performance of home care and home management tasks in accordance with the individual's plan of care.

CRS services may include:

- (1) Supervision and oversight.
- (2) Supportive services, such as:
 - a. Socialization as part of the approved plan of care and not diversional or recreational; and

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

- b. Assisting individuals in arranging meetings and appointments, and providing transportation.
- (3) Individualized home care assistance tasks, such as:
- a. Preparing modified diets, for example, diabetic or low sodium diets;
 - b. Reminding individuals to take medications or to perform exercises;
 - c. Household chores when the individual's care requires the prevention of exposure to infectious disease or containment of infectious disease; and
 - d. Assisting with dressing, oral hygiene, hair care, grooming and bathing.
- (4) Individualized home management tasks, such as:
- a. Housekeeping;
 - b. Laundry;
 - c. Preparation of regular snacks and meals; and
 - d. Shopping.

Community residential services may provide up to twenty-four (24) hour services

Individuals not living with a caregiver are eligible to receive community residential

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

services. Persons currently residing with a caregiver, but who are demonstrating maladaptive behavior that places themselves, their caregivers or others at significant risk of injury or jeopardy are also eligible for CRS if the caregiver is unable to effectively manage the behavior or the risk it presents, resulting in the need for removal from the home to a more structured setting. Persons whose behaviors may result in legal problems if not ameliorated, are eligible for this service.

The purpose of twenty-four (24) hour CRS coverage shall be to allow time to transition the individual into the community and to make alternative arrangements for necessary supervision.

The provider's time spent in the home during the individual's absence shall not be a covered community residential service.

Priority for locating existing alternative living arrangements that will continue to be available to the individual after he or she is no longer receiving waiver services will be given to those individuals for whom, based upon their progress, needs, and abilities, it may be projected that they no longer meet nursing facility level of care within the next six months. The interdisciplinary team, with the involvement of the individual will develop a transition plan that reflects the services and supports the individual will need following discharge from the waiver, the resources available to obtain those services and supports, the plan for obtaining those resources, and who is responsible for obtaining

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION IV - CONDITIONS FOR PARTICIPATION

or assisting the individual in obtaining those resources. It is the case manager's responsibility to ensure that the plan is developed, to ensure that identified services and supports are obtained, and to assist the individual in locating existing alternative living arrangements.

The staffing ratio for CRS services shall not exceed three (3) ABI waiver individuals per one (1) direct service staff person in a staffed residence.

When CRS services are provided in a group home, the staffing ratio for CRS services shall be sufficient to ensure the individual's health, welfare, and safety, and to ensure that the individual's plan of care is implemented.

Community-residential services shall be necessary to prevent institutionalization and to assist the individual in his rehabilitation and re-entry into the community.

Community residential services shall not include the cost of room and board.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION V - ACQUIRED BRAIN INJURY
SERVICE COVERAGE REQUIREMENT

V. ACQUIRED BRAIN INJURY WAIVER SERVICE COVERAGE
REQUIREMENTS

A. Prior Authorization Procedures

1. The Department for Medicaid Services or its designated agent shall prior authorize all Acquired Brain Injury Waiver Program services to ensure that the:
 - (a) Level of care criteria and ABI waiver service eligibility requirements are met;
 - (b) ABI waiver services are defined in the approved plan of care;
 - (c) Services are medically necessary and of a direct or remedial benefit to prepare the individual for re-entry into the community;
 - (d) ABI waiver services prevent institutionalization and prepare the individual to reside in the community without continued ABI waiver services;
 - (e) Services are adequate to meet the individual's needs; and
 - (f) Cost of services shall not reasonably be expected to exceed the cost of the appropriate level of institutional care.

Consideration shall be given to the individual's home situation, the caregiver support available, type and amount of service requested, and that NF placement may be recommended without ABI waiver services.

2. The prior authorization process consists of three (3) steps as follows:

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION V - ACQUIRED BRAIN INJURY
SERVICE COVERAGE REQUIREMENT

- (a) The case management agency shall request and obtain by telephone a nursing facility level of care determination.
- (b) Upon receipt of the written level of care determination, the ABI Waiver Program case manager shall submit to the PRO the following information to request a determination of the individual's medical eligibility for ABI waiver services:
 - (1) A copy of the Acquired Brain Injury Plan of Care form (MAP-4097). (At this time the case manager is not required to identify specific providers.)
 - (2) A completed MAP-4099 form signed and dated by the individual's attending physician recommending the ABI Waiver Program; (NOTE: Signature stamps are not acceptable);
 - (3) The Kentucky Medicaid Certification Form (MAP-350); and
 - (4) The Peer Review Organization's (PRO) Certification for Nursing Facility Services Form.

The level of care determination for admission to and continued stay in the ABI waiver program shall be made by the PRO's registered professional nurses, with telephone consultation with a Kentucky-licensed physician if necessary. The consultant physician shall:

- (1) Be a physical medicine and rehabilitation physician (physiatrist) or a physician (neurologist, orthopedist, etc.) who is qualified by virtue of his training and experience in

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION V - ACQUIRED BRAIN INJURY
SERVICE COVERAGE REQUIREMENT

rehabilitation; and

- (2) Have two (2) years full-time experience in the management of rehabilitation services in a brain injury program.
- (c) The ABI Waiver Program case manager shall submit to the Department for Medicaid Services or its designated agent the following information for approval of the plan of care and ABI waiver service eligibility:
 - (1) A completed Plan of Care form (MAP-4097);
 - (2) A copy of the level of care confirmation notice;
 - (3) A copy of the notification of ABI Waiver Program eligibility from the PRO;
 - (4) A completed MAP-4099 form signed and dated by the individual's attending physician recommending the ABI Waiver Program;
 - (5) The Kentucky Medicaid Certification Form (MAP-350); and
 - (6) A completed "Acquired Brain Injury Waiver Services Program Applicant/Recipient Memorandum of Understanding" (MAP-4096.)

The Department for Medicaid Services or its designated agent shall review the Plan of Care taking into consideration the appropriateness of the plan for services and the cost-effectiveness in providing the services in the community rather than in a nursing facility.

B. Approval

The ABI waiver case management agency that initiates the request

SECTION V - ACQUIRED BRAIN INJURY
SERVICE COVERAGE REQUIREMENT

for services for an individual who is subsequently approved for ABI Waiver Program services shall receive written approval from the Department for Medicaid Services or its designated agent. Reimbursement shall not be made for services rendered prior to the authorization of service coverage.

C. Denial

The individual and the ABI waiver case management agency that initiated the request for services shall receive notification when an individual has been denied ABI waiver service coverage.

The individual's hearing and appeal rights are established in accordance with 907 KAR 1:560 and 907 KAR 1:563.

D. Modifications

All modifications of the plan of care shall be prior authorized. The ABI waiver service case management agency shall notify the Department for Medicaid Services or its designated agent of a modification by submitting the following information:

1. An ABI Plan of Care Modification Form (MAP-4098);
2. A MAP-95 if environmental modifications or specialized medical equipment and supplies are requested; and
3. A brief explanation of the need to increase service, extend service, reduce service, or add environmental modifications or specialized medical equipment.

E. Re-evaluation

A re-evaluation shall be conducted at least every six (6) months to determine the individual's continued eligibility for nursing facility level of care and continued ABI waiver coverage.

The case manager shall:

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION V - ACQUIRED BRAIN INJURY
SERVICE COVERAGE REQUIREMENT

1. Request and obtain a level of care determination by the PRO at least every six (6) months; and
2. Submit the current level of care confirmation notice along with an updated plan of care to the Department for Medicaid Services or its designated agent.

This information shall be used for the determination of continued ABI waiver eligibility and prior authorization.

F. Terminations

The Department for Medicaid Services or its designated agent and the Department for Community Based Services (DCBS) shall be notified immediately whenever a recipient has been terminated from the ABI Waiver Program. Upon discharge of an individual from the ABI Waiver Program, the individual's case management provider shall complete the first seven (7) blanks of a MAP-24B and submit the MAP-24B to the:

1. The DCBS local office where the family or interested party representing the applicant resides; and
2. Department for Medicaid Services or its designated agent.

The following procedure shall be followed if an individual is receiving ABI Waiver service and is admitted to a rehabilitation facility or a NF:

1. The ABI waiver case management provider shall complete an entire MAP-24B form, and submit one (1) copy of the form to the local DCBS office, and a copy of the form to the Department for Medicaid Services or its designated agent. If an individual receives a temporary discharge from ABI waiver services for not more than sixty (60) days, the MAP-24B form shall so state and the individual is not required to be terminated.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

SECTION VI - REIMBURSEMENT

VI. REIMBURSEMENT

Reimbursement under ABI Waiver Program is limited to services provided in accordance with the individual's approved plan of care.

Reimbursement shall be at the lesser of a provider agency's usual and customary charge or the Medicaid fixed upper payment limit. Reimbursement shall not exceed the Medicaid fixed upper payment limit.

Services provided by family members shall not be reimbursed. Providers shall not enter into an employee or contractual arrangement with an individual's family member for the purpose of providing waiver services.

Following are the procedure codes by type of service, unit of service and the Medicaid fixed upper payment limit:

Procedure Code	Community Residential Service	Unit of Service	Fixed Upper Payment Limits
X0100	Group Home	Not Applicable	\$90.00
X0101	Staffed Residence	Not Applicable	\$200.00

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY WAIVER SERVICES PROGRAM
PHYSICIAN CERTIFICATION FORM
MAP-4099

MAP-4099

KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY WAIVER
SERVICES PROGRAM
PHYSICIAN CERTIFICATION FORM

TO: _____

AGENCY: _____

ADDRESS: _____

_____ PHONE: _____

PHYSICIAN'S RECOMMENDATION

I recommend the Acquired Brain Injury Waiver Services Program for:

CLIENT: _____

ADDRESS: _____

_____ PHONE: _____

SOCIAL SECURITY #: _____ MAID #: _____

DIAGNOSIS (ES): _____

I certify that if acquired brain injury waiver services were not available, nursing facility placement shall be appropriate for this individual in the near future.

PHYSICIAN'S NAME: _____ UPIN #: _____

ADDRESS: _____

_____ PHONE: _____

SIGNATURE

DATE

**LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM
CERTIFICATION FORM**

I. ESTATE RECOVERY

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/MR/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

Signature

Date

II. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, BRAIN INJURY WAIVER

A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement is requested _____; is not requested _____.

Signature

Date

B. This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD is requested _____; is not requested _____.

Signature

Date

C. MODEL WAIVER II - This is to certify that I/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement is requested _____; is not requested _____.

Signature

Date

D. BRAIN INJURY (BI) WAIVER - This is to certify that I/legal representative have been informed of the BI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested _____; is not requested _____.

Signature

Date

III. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

Signature

Date

IV. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

Signature

Date

V. RECIPIENT INFORMATION

Medicaid Recipient's Name: _____

Address of Recipient: _____

Phone: _____

Medicaid Number: _____

Responsible Party/Legal Representative: _____

Address: _____

Phone: _____

Signature and Title of Person Assisting with Completion of Form:

Agency/Facility: _____

Address: _____

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

RANCHO SCALE

RANCHO SCALE

<u>LEVEL</u>	<u>RESPONSE</u>
I.	<u>No response</u> Patient is completely unresponsive to any stimulus.
II.	<u>Generalized response</u> Patient reacts to the environment, but not as a specific response to the stimulus - responses are often the same despite change of stimuli. The earliest response is often gross movement to deep pain.
III.	<u>Localized response</u> Patient reacts in a specific manner to the stimulus, but may inconsistently turn head to sound, withdraw an extremity to pain, squeeze fingers placed in the hand, or respond to family members more than others.
IV.	<u>Confused, agitated</u> Patient is in a heightened state of activity, but is still severely detached from the surroundings. Internal confusion and very limited ability to learn is combined with short attention span and easy fatigue. The patient is unable to cooperate and may be aggressive, combative, or incoherent.
V.	<u>Confused, inappropriate/non-agitated</u> Patient appears alert and is able to respond to simple commands. Responses are best with familiar routines, people, and structured situations. Distractibility and short attention span lead to difficulty learning new tasks and agitation in response to frustrations. If physically mobile, there may be wandering. Much external structure is needed. Initiation and memory are limited.
VI.	<u>Confused, appropriate</u> Patient shows goal-directed behavior, but still is dependent on external structure and direction. Simple directions are followed consistently and there is carry-over of relearned skills (like dressing), yet new learning progresses very slowly with little carry-over. Orientation is better and there is no longer inappropriate wandering.
VII.	<u>Automatic, appropriate</u> Patient appears appropriate and oriented within familiar settings such as home and hospital, but is confused and often helpless in unfamiliar surroundings. The daily routine can be managed with minimal confusion as long as there are no changes. There is little recall of what has just been done. There is only a superficial understanding of the disability, with lack of insight into the significance of the remaining deficits.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

RANCHO SCALE

VII. continued

Judgement is impaired with inability to plan ahead. New learning is slow and minimal supervision is needed. Driving is unsafe; supervision is needed for safety in the community or in school and workshop settings.

VIII.

Purposeful, appropriate

Patient may not function as well as before the injury, but is able to function independently in home and community skills, including driving. Alert, oriented, and able to integrate past and present events. Vocational rehabilitation is indicated. Difficulties dealing with stressful or unexpected situations can arise, as there may be a decrease in abstract reasoning, judgement, intellectual ability, and tolerance of stress relative to premorbid capabilities.

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY WAIVER SERVICES PROGRAM
APPLICANT/RECIPIENT MEMORANDUM OF UNDERSTANDING
MAP-4096

MAP - 4096

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY WAIVER SERVICES PROGRAM
APPLICANT/RECIPIENT MEMORANDUM OF UNDERSTANDING

I, _____, and/or _____, my legal representative or
Applicant Name
family member have been informed on _____ and understand the following:
Date

1. The Medicaid Acquired Brain Injury Waiver Services Program provides temporary part-time assistance to me, _____, and others who are
Applicant Name
involved in my care;
2. The acquired brain injury services are available only so long as my care needs meet the Kentucky Medicaid Program nursing facility level of care requirements which allow Medicaid payment;
3. The provision of services under the Program do not replace services provided by family members and other community resources at no cost to the Medicaid Program;
4. To be Medicaid-reimbursed, acquired brain injury waiver services shall be provided in accordance with the written plan of care developed by health care professionals who are assisting me with my rehabilitation and retraining (the plan of care is developed with my knowledge and input);
5. I and my caregivers are obligated to actively participate and cooperate in all rehabilitation and retraining provided to me by the Acquired Brain Injury Waiver Program as we work toward the common goal of my discharge from the Program; and,
6. I and my caregivers are obligated to actively work together toward a common goal of discharge from the Program.

I and/or my legal representative also acknowledge and accept that I shall be discharged from the Acquired Brain Injury Waiver Services Program:

1. At such time the Department for Medicaid Services, or its designated agent, determines that I no longer meet the nursing facility level of care criteria;

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY WAIVER SERVICES PROGRAM
APPLICANT/RECIPIENT MEMORANDUM OF UNDERSTANDING
MAP-4096

MAP -4096
Page Two

2. When it is determined by the Department for Medicaid Services, or its designated agent, that the provision of waiver and other Medicaid-covered services in the community are more expensive than they would be if provided in a nursing facility; and/or,
3. When it is determined by the Department for Medicaid Services, or its designated agent, that I am able to function in the community without acquired brain injury waiver services with the assistance of family, other informal supports and community services that are usually available.

We further understand that my Medicaid financial eligibility could end upon discharge from the Waiver Program, if my eligibility is based on the special income provision of the Acquired Brain Injury Waiver Services Program or spend-down.

I have been informed of my appeal rights under the Acquired Brain Injury Waiver Services Program.

Recipient/Applicant	Legal Counsel (If Applicable)	Date
---------------------	-------------------------------	------

Family Member	Relationship	Date
---------------	--------------	------

Legal Representative	Title	Date
----------------------	-------	------

Case Manager/Witness	Employer Agency	Date
----------------------	-----------------	------

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

HOME AND COMMUNITY-BASED SERVICES PROGRAM
ACQUIRED BRAIN INJURY
PLAN OF CARE
MAP-4097

MAP-4097

HOME AND COMMUNITY-BASED SERVICES PROGRAM
ACQUIRED BRAIN INJURY
PLAN OF CARE

Recipient Information: Anticipated Length of Stay: _____

Name: _____ Medicaid #: _____

Current Living Arrangement: _____ Own Home _____ Personal Care Home

_____ Group Home _____ Family Care Home

_____ Alternative Living Arrangement _____ Community Residential Services

_____ Other, please specify: _____

Name of Facility if other than own home: _____

Address: _____ Level of Care Dates: _____

_____ Date of Birth: _____

_____ Rancho Scale: _____

Case Manager: _____ Telephone: _____

Agency Name and Provider Number: _____

Address: _____

Diagnosis/Condition that is focus of treatment: _____

Onset/Date of Injury: _____

Circumstances/Cause of Injury: _____

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

HOME AND COMMUNITY-BASED SERVICES PROGRAM
ACQUIRED BRAIN INJURY
PLAN OF CARE
MAP-4097

Summary of Neurological Findings and Impressions

Cognitive/Motor/Sensory/Visual Functioning - Abilities/Impairments: _____

Communication (Speech/Hearing) Skills/Limitations: _____

Summary of Past Medical History and Current Medical Status: _____

Current Medications (Include Name, Dosage, Frequency and Purpose):

Allergies: _____

Physical Challenges/Accommodations (Address all limitations such as self care and mobility): _____

Inappropriate/Maladaptive Behaviors that are a focus of concern: _____

Summary of Secondary Mental Health or Substance Abuse Disorders (Specify Axis I or Axis II Condition if applicable): _____

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

HOME AND COMMUNITY-BASED SERVICES PROGRAM
ACQUIRED BRAIN INJURY
PLAN OF CARE
MAP-4097

Identified Mental Health Treatment Needs (if applicable): _____

Vocational Issues (if applicable): _____

Identified Safety Issues Related to ALL Areas: _____

Summary of Family and Social Relationships
Current Family Members and Their Involvement: _____

Friends/Companions/Partners and Their Involvement: _____

Plan for Community Reintegration: _____

Designated Caregiver (if other than legal representative):
Name: _____ Phone #: _____
Address: _____

ACQUIRED BRAIN INJURY
PLAN OF CARE MODIFICATION
MAP-4098

MAP-4098

Acquired Brain Injury
Plan of Care Modification

Effective Date of Requested Change: _____

Case Management Agency: _____

Individual's Name: _____

MAID # _____

What has happened to the individual which necessitates a
plan change?

Changes Requested:

Service/Code Provider Number Frequency/Duration Cost

A. Addition _____

B. Deletion _____

C. Changes _____

Who participated in the decision-making which determined the
need for plan change?

Case Managers Signature

Date

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
REQUEST FOR EQUIPMENT FORM
MAP-95

MAP-95
(Rev. 04-88)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
REQUEST FOR EQUIPMENT FORM

RECIPIENT'S NAME _____ MAID # _____ BIRTHDATE _____
Mo Day Yr

List Other Insurance Coverage _____

Estimated Time Needed # _____ Months _____ Indefinitely _____ Permanently

Specific Equipment Item Requested: Please include Medicare codes for parts to items such as Braces, Prostheses, and Wheelchairs (if applicable). Otherwise, group parts together under Code E1399 or appropriate miscellaneous code for braces/prostheses.

PURCHASE:

<u>Item</u>	<u>Code</u>	Manufacturer's Suggested List Price (IC Items Only)	Agency's Acquisition Cost (All Items)

Trade Name/Model Number of Equipment Item (if applicable) _____

Manufacturer's Name _____

RENTAL:

If Rental is Requested, Please Specify Amount \$ _____

Supplier of Equipment _____

Address _____

Date of Delivery if Equipment Item is Already Placed in Home - Date _____

Agency Name _____ Provider # _____

Authorized Signature _____

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

DEPARTMENT FOR COMMUNITY BASED SERVICES FORM
MAP-24B

MAP 24B



CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

TO: _____ County Office
Department for Community Based Services

FROM: (1) _____
Department for Mental Health/Mental Retardation

DATE: (2) _____

SUBJECT: Brain Injury Waiver Admission/Discharge

(3) _____
(last name) (last name) (mi) (social security number)

(4) _____ KY _____
(address) (city) (zip) (phone #)

(5) Was admitted/discharged to the Brain Injury Waiver Program on _____
(date)

(6) The case manager is _____
(name) (phone #) (provider #) (cost)

(7) _____ KY _____
(address) (city) (zip)

(8) Primary Provider: _____
(name) (phone #) (provider #) (cost)

(9) _____ KY _____
(address) (city) (zip)

(10) _____
(name) (phone #) (provider #) (monthly cost)

(11) _____
(name) (phone #) (provider #) (monthly cost)

(12) _____
(name) (phone #) (provider #) (monthly cost)

(13) _____
(name) (phone #) (provider #) (monthly cost)



CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

ACQUIRED BRAIN INJURY SERVICES
AND REIMBURSEMENT PROGRAM MANUAL

DEPARTMENT FOR COMMUNITY BASED SERVICES INSTRUCTIONS
MAP-24B

Procedural Instructions for MAP 24B

Upon discharge of an individual from the Acquired Brain Injury Waiver Program, the case manager shall forward a MAP-24B form to the local office, Department for Community Based Services and the Department for Mental Health/Mental Retardation Services. The case manager shall complete the form through line seven (7).

This form is also to be used by the Department for Mental Health/Mental Retardation Services to notify the Department for Community Based Services when a Medicaid applicant/recipient is admitted to or discharged from the Acquired Brain Injury Waiver Program. These forms should be mailed to the local Department for Community Based Services office where the family or interested party of the applicant/recipient resides. A copy of the MAP 24B form should be mailed to the case manager.

Use the following instructions to fill in the blanks on the MAP 24B.

Line One (1): List name of Department for Mental Health/Mental Retardation staff person who completed the MAP 24B form.

Line Two(2): List the date the form was prepared.

Line Three (3): List the last name, middle initial and social security number of the recipient/applicant.

Line Four (4): List the complete address and telephone number of the recipient/applicant.

Line Five (5): Circle admitted or discharged as appropriate and list date applicant/recipient was admitted/discharged to the brain injury program. If the provider changes, submit a MAP 24B form for the discharge and another MAP 24B form for the admission.

Line Six (6): List the name, phone number, case management agency, provider number of the case manager and the monthly case management cost of the case manager.

Line Seven (7): List the complete address of the case manager.

Line Eight (8): List the name, phone number, provider number and the monthly cost of the services to be provided by the primary provider. This should be the provider with the highest anticipated monthly costs.

Line Nine (9): List the complete address of the primary provider.

Line Ten (10), Eleven (11), Twelve (12) and Thirteen (13): List the name, phone number, provider number and monthly costs for each additional provider.

Instructions for Completing Part I of Incident Report

The approved form must be used as written and not altered in any way.

Complete all blanks on the form

Check appropriate incident class

Description of Incident: the person witnessing or discovering the incident must complete this section. The incident analysis must be detailed and include all participants and their involvement in the incident. Where appropriate, individual's actions and staff response should be documented.

SUMMARY OF REPORTING REQUIREMENTS:

<i>Who Reports:</i>	<i>Reportable to:</i>	Class I	Class II	Class III
Provider Agency	Case Manager	Within 24 hours of discovery	Within 24 hours of discovery	Within 8 hours of discovery
Provider Agency	MHMR/BISU	Not reportable	Within 24 hours of discovery, followed by complete written report within 10 calendar days of discovery	Within 8 hours of discovery, followed by complete written report within 7 calendar days of discovery
Provider Agency	Guardian	Report as indicated by guardian	Within 24 hours of discovery, followed by complete written report within 10 calendar days of discovery	Within 8 hours of discovery, followed by complete written report within 7 calendar days of discovery
Provider Agency	DCBS	N/A	N/A	Within 8 hours of discovery

INCIDENT REPORT (Part II)
(DESIGNATING INCIDENT CODES)
 (Check ALL That Apply)

- A SUSPECTED/ALLEGED ABUSE**
- 1 Emotional, Community Person to Individual
 - 2 Emotional, Parent/Family to Individual
 - 3 Emotional, Individual to Individual
 - 4 Emotional, Staff to Individual
 - 5 Physical, Community Person to Individual
 - 6 Physical, Parent/Family to Individual
 - 7 Physical, Individual to Individual
 - 8 Physical, Staff to Individual
 - 9 Sexual, Community Person to Individual
 - 10 Sexual, Parent/Family to Individual
 - 11 Sexual, Individual to Individual
 - 12 Sexual, Staff to Individual
 - 13 Verbal, Community Person to Individual
 - 14 Verbal, Parent/Family to Individual
 - 15 Verbal, Individual to Individual
 - 16 Verbal, Staff to Individual
 - 17 Unknown

- B SUSPECTED/ALLEGED NEGLECT**
- 1 Community Person to Individual
 - 2 Parent/Family to Individual
 - 3 Staff to Individual
 - 4 Unknown

- C SUSPECTED/ALLEGED EXPLOITATION**
- 1 Community Person to Individual
 - 2 Parent/Family to Individual
 - 3 Individual to Individual
 - 4 Staff to Individual
 - 5 Unknown

- D DEATH OF PERSON**
- 1 Accident
 - 2 Criminal Act
 - 3 Illness
 - 4 Natural Causes
 - 5 Suicide

- E RESTRAINT**
- 1 Unnecessary Restraint
 - 2 Emergency Chemical Restraint
 - 3 Emergency Physical Restraint
 - 4 Emergency Mechanical Restraint

- F SEVERE BEHAVIORAL ISSUES**
- 1 Sexual Contact
 - 2 Threatened Suicide
 - 3 Attempted Suicide
 - 4 Severe Behavior Outburst
 - 5 Property Damage
 - 6 Self Abuse
 - 7 Individual aggressed to Staff

- G SERVICE SITE/RESIDENCE UNINHABITABLE**
- 1 Loss of Electric
 - 2 Loss of Heat
 - 3 Loss of Water
 - 4 Other Safety Issues

- H SERVICE SITE/RESIDENTIAL FIRE**
- 1 Requiring Relocation
 - 2 Resulting in Personal Injury
 - 3 Resulting in Property Loss

- I ACT UNACCEPTABLE BY PUBLIC**
- 1 Individual
 - 2 Staff

- J HOSPITAL VISIT/ADMISSION**
- 1 Emergency Room
 - 2 In-patient
 - 3 Medical
 - 4 Medical, Medication Therapy IV
 - 5 Medical, Surgery
 - 6 Psychiatric, Behavior reasons

- K PERSON MISSING FROM**
- 1 Structured Day Program Site
 - 2 Residence
 - 3 Community
 - 4 Other

- L ADMISSION TO NURSING FACILITY**
- 1 Medical Needs
 - 2 Rehabilitative Needs

- M SERIOUS INJURY RESULTING IN**
- 1 Cast Applied
 - 2 Medical Procedure (MRI, Xray)
 - 3 Medication
 - 4 Referral to other Physician
 - 5 Splints
 - 6 Stitches/Staples
 - 7 Wrapping
 - 8 Other

- N MEDICATION ERROR**
- 1 Dose(s) Missed Entirely
 - 2 Not within admin window when due
 - 3 Wrong Dose Given
 - 4 Wrong Medication Given
 - 5 Wrong Route

- O CRIMINAL ACTION AS VICTIM/PERPETRATOR**
- 1 Arrested
 - 2 Victim of a Crime
 - 3 Other

- P INJURED PART OF BODY**
- 1 Abdomen
 - 2 Ankle Left
 - 3 Ankle Right
 - 4 Anus
 - 5 Arm Left
 - 6 Arm Right
 - 7 Back Left
 - 8 Back Right
 - 9 Buttocks
 - 10 Chest Left
 - 11 Chest Right
 - 12 Chin
 - 13 Collarbone
 - 14 Ears
 - 15 Eyes
 - 16 Face
 - 17 Fingers Left Hand
 - 18 Fingers Right Hand
 - 19 Foot Left
 - 20 Foot Right
 - 21 Genitals
 - 22 Groin Area
 - 23 Hand Left
 - 24 Hand Right
 - 25 Head Back
 - 26 Head Front
 - 27 Knee Left
 - 28 Knee Right
 - 29 Leg Left
 - 30 Leg Right
 - 31 Lips
 - 32 Mouth
 - 33 Neck
 - 34 Nose
 - 35 Rib
 - 36 Shoulder Left
 - 37 Shoulder Right
 - 38 Teeth

- 43 Hip
- 44 Wrist Left
- 45 Wrist Right

- Q CAUSE OF INJURY**
- 1 Accident
 - 2 Bite/Sting
 - 3 Equipment Failure
 - 4 Equipment Operator Error
 - 5 Fall
 - 6 Individual's Behavior
 - 7 Lift/Transfer Error
 - 8 Medical Condition
 - 9 Scalding
 - 10 Staff Person
 - 11 Unsafe Condition, Service Site
 - 12 Unsafe Condition, Home
 - 13 Other

- R TYPE OF INJURY/EMERGENCY CONDITIONS**
- 1 No Apparent Injury
 - 2 Abrasions
 - 3 Allergic Reaction
 - 4 Angina/Chest Pain
 - 5 Aspiration
 - 6 Asthma
 - 7 Bedsores
 - 8 Blister
 - 9 Blood Clot
 - 10 Bone Breaks/Fractures
 - 11 Bowel Blockage
 - 12 Bronchitis
 - 13 Bruises/contusions
 - 14 Burns
 - 15 Chafed/Chapped
 - 16 Choking
 - 17 Communicable Disease
 - 18 Concussion
 - 19 Constipation
 - 20 Cracked/Missing Tooth
 - 21 Dehydration
 - 22 Diarrhea
 - 23 Dislocation
 - 24 Gout
 - 25 Heart Rhythm Irregularities
 - 26 Hematoma
 - 27 Hepatitis
 - 28 High Blood Pressure
 - 29 High Blood Sugar
 - 30 Irritation/Rash
 - 31 Laceration
 - 32 Lesion
 - 33 Low Blood Sugar
 - 34 Malnutrition
 - 35 Nausea/Vomiting
 - 36 Pneumonia
 - 37 Puncture
 - 38 Scabies
 - 39 Seizures
 - 40 Significant Infection
 - 41 Skin Ulcers
 - 42 Soft Tissue Swelling
 - 43 Spasms
 - 44 Sprains
 - 45 Strains
 - 46 Stroke
 - 47 Sunburn
 - 48 Swallowing Objects

MAID/SS#: _____ Name: _____ Incident Date: _____

INCIDENT REPORT PART III (cont)
(DESIGNATING INCIDENT CODES)
(Check ALL That Apply)

J HOSPITAL VISIT/ADMISSION (cont)

- 7 Psychiatric, Medication Adjustment
- 8 Psychiatric, Suicidal
- 9 Psychiatric, Threat to Others

P INJURED PART OF BODY (cont)

- 39 Throat
- 40 Toes Left
- 41 Toes Right
- 42 Other

**R TYPE OF INJURY/EMERGENCY
CONDITIONS (cont)**

- 49 Ulcers
- 50 Upper Respiratory Infection
- 51 Urinary Tract Infection
- 52 Other

***Instructions for Completing Part II of Incident Report
(Designating Incident Codes)***

Check all areas that apply to the incident.

Do not write in changes to items checked. If item doesn't apply as stated on the form, do not check it.

Most incidents will require multiple checks to fully describe the incident.

If "unknown" or "other" is checked in any area, then details should be provided in the narrative.

INCIDENT REPORT (PART III)
(SUPERVISOR/CASE MANAGER REVIEW)

INCIDENT FOLLOW-UP:

Analysis of incident, staff action taken and incident follow-up: _____

How can this incident be avoided in the future? (who made this decision) _____

Staff training needs identified (include training plan and who's responsible): _____

Individual support needs identified: _____

Current Status: _____

Submitted by: _____ Title: _____ Date: ___/___/___

Additional Signatures:

_____	Title: Case Manager	Date: ___/___/___
_____	Title: _____	Date: ___/___/___
_____	Title: _____	Date: ___/___/___

***Instructions for Completing Part III of Incident Report
(Supervisor/Case Manager Review)***

The information in this section summarizes the results of follow-up needed for Class I incidents or the investigations conducted for Class II and Class III incidents.

The follow-up should include a critique of staff response and action taken. This critique should analyze what occurred before and after the incident to help determine if staff responded appropriately.

Also included should be a plan to ensure that the incident does not occur again as well as stating who was involved in developing this plan. Preferably actual or planned dates of completion would be included.

Staff training needs identified as a result of incident follow-up/investigation, along with a training plan, would be included in this section.

Also included should be a statement about the current situation of the individual involved in the incident.

Person completing the follow-up from the provider agency shall sign along with the Case Manager and other relevant parties.