

Choices for Care Moderate Needs Group

Program Operations Manual

May 2016

VERMONT AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
ADULT SERVICES DIVISION
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<http://asd.vcms.vt.dev.cdc.nicusa.com/>

Available in alternative formats upon request.

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Manual Changes Log

April 2014: Added Flexible Funding section to correspond with implementation of new service.

August 2015: Added ICD 10 Code section to correspond with implementation of ICD 10 billing codes October 2015.

May 2016: Updated Preface for Global Commitment consolidation January 2016 and new Waterbury State office contact information.

PREFACE

The Choices for Care program operates within the State's Global Commitment to Health waiver. This program provides long-term care services and supports to elderly or physically disabled Vermont adults who are eligible under the conditions of the Waiver as approved by the federal government. The primary goal of Choices for Care is to provide Vermonters with equal access to either nursing facility care or home and community-based services, according to their choice. This program is subject to approval by the Centers for Medicare and Medicaid (CMS), and is managed in compliance with the GC Special Terms & Conditions approved by CMS.

The Department of Disabilities, Aging and Independent Living (DAIL) has developed this operational protocol manual for the purpose of describing the eligibility criteria, services and program procedures to assist individuals, case managers and service providers in planning and managing services. This manual shall act as a companion to existing Vermont State regulations.

DAIL shall revise and distribute this manual to provider agencies and other interested parties as necessary. A current version will be maintained online at the DAIL, Division of Disabilities and Aging Services (DDAS) website at <http://asd.vcms.vt.dev.cdc.nicusa.com/>. Please forward any comments or suggestions regarding this manual to "Choices for Care" Administration, Vermont Department of Disabilities, Aging and Independent Living, 280 State Drive, HC2 South, Waterbury, VT 05671-2070 or (802) 241-0294.

This manual is dedicated to the caregivers and staff throughout Vermont who work diligently to support individuals to live with dignity and respect in the setting of their choice. Without their ongoing commitment to serving Vermonters, the "Choices for Care" program would neither exist nor succeed.

Glossary of Terms

AAA: Area Agency on Aging

Activities of Daily Living (ADL): Activities, as defined by the Department of Disabilities, Aging and Independent Living (DAIL), that are essential for self care, such as bathing, eating, transferring and toileting.

Adult Protective Services (APS): The unit within the Division of Licensing and Protection (DLP) responsible for processing, investigating and prosecuting reports of abuse, neglect and exploitation against vulnerable adult Vermonters.

Agency: A private non-profit organization which provides care or services.

Agency of Human Services: The Vermont state agency responsible for oversight of the Department of Disabilities, Aging and Independent Living (DAIL).

Applicant: An individual who has applied to the “Choices for Care”, Moderate Needs Group program to receive services.

Assessment: The tool and process used to document an individual’s strengths, needs, and unmet needs as they relate to health, social and functional status. The assessment is used to determine clinical eligibility for “Choices for Care”.

Authorized Representative: An individual who has been given legal authority to act on behalf of an applicant or participant.

Centers for Medicare and Medicaid Services (CMS): The federal office responsible for approving and monitoring the “Choices for Care” program.

“Choices for Care”: The program name used to identify Vermont Long-Term Care Medicaid services.

Choices for Care Team: The group of local provider agencies and other relevant organizations which meets on a regular basis to collaborate in managing “Choices for Care”, VT Long-Term Care Medicaid services, in accordance with the local/regional protocol.

Consumer: A person who has applied for services or who receives services.

Department for Children and Families (DCF): The state department within the Vermont Agency of Human Services (AHS) with primary authority for the state financial eligibility determination for “Choices for Care”, VT Long-Term Care Medicaid services. DCF is also responsible for administration of other state health care and financial benefits for Vermonters.

Department of Disabilities, Aging and Independent Living (DAIL): The state department within the Vermont Agency of Human Services (AHS) with primary authority for the state management, approval, and oversight of “Choices for Care”, VT Long-Term Care Medicaid services.

Division of Disability and Aging Services (DDAS): The division within the Department of Disabilities, Aging and Independent Living (DAIL) that is responsible for managing the “Choices for Care”, Long-Term Care Medicaid program.

Division of Licensing and Protection (DLP): The division within the Department of Disabilities, Aging and Independent Living (DAIL) responsible for the licensing and regulation of skilled nursing facilities, residential care homes, assisted living residences, and Medicare certified home health agencies. Adult Protective Services (APS) is located in DLP.

Home Health Agency (HHA): A Medicare Certified, non-profit home care service agency, authorized to provide “Choices for Care”, VT Long-Term Care Medicaid

(LTCM) services.

Instrumental Activities of Daily Living (IADL): Household tasks and other activities, as defined by the Department of Disabilities, Aging and Independent Living (DAIL), needed to meet one's needs while living in the community such as cleaning, cooking, shopping, managing medication, using transportation, and managing money.

Independent Living Assessment (ILA): An assessment tool used to document an individual's strengths and needs as they relate to health, social and functional status in the home-based setting.

Individual: A person who has applied for or is participating in "Choices for Care" (CFC), VT Long-Term Care Medicaid.

Legal Representative: An individual who has the legal authority, via a power of attorney document or court appointed guardianship, to make decisions or perform certain activities on behalf of another person.

Moderate Needs Coordinator: DAIL Staff that administers the Moderate Needs Program.

Office of Vermont Health Access (OVHA): The division within the Department for Children and Families responsible for administration and oversight of Vermont health care benefits.

Participant: A person who has been found eligible and receives VT Long-Term Care Medicaid services.

PASARR: "Pre-Admission Screening and Annual Resident Review", used to identify a need for active treatment due to a mental illness or mental retardation.

Provider: An individual, organization, or agency that has been authorized by the Department to provide "Choices for Care", Long-Term Care Medicaid services.

Recipient: A person who receives services.

Reimbursement: Payment for services which have been provided by a person or organization.

Service Authorization: A form completed by DAIL that authorizes Moderate Needs services for a specified time period which when approved by DAIL gives provider organizations authority to provide CFC services and submit claims for reimbursement.

SECTION I. General Policies

- A. Choices for Care (CFC) services shall be based on person-centered planning and shall be designed to ensure quality and to protect the health and welfare of the individuals receiving services.
- B. Choices for Care (CFC) services shall be provided in a cost-effective and efficient manner, preventing duplication of services, unnecessary costs, and unnecessary administrative tasks. The Department shall manage long term care services so as to use resources efficiently, and to maximize the benefits and services available to the greatest number of eligible individuals.
- C. The Department shall administer the “Choices for Care” program in accordance with existing regulations and an Operational Protocol.
- D. Variances to existing regulations and the Operational Protocol may be granted at the discretion of the Department, upon a determination that:
 - 1. Strict compliance would impose a substantial hardship on the individual;
 - 2. Granting the variance will further the goals and general policies of the Waiver; and
 - 3. The variance is necessary to protect or maintain the safety, health and welfare of the individual.
- E. Individuals shall be informed of feasible service alternatives.
- F. Consistent with federal terms and conditions, the Department shall have the authority to implement different elements of the “Choices for Care” program at different times, including different regions of Vermont at different times.

SECTION II. **Eligibility**

I. General Eligibility

A. To be eligible for the “Choices for Care”, VT Long-Term Care Medicaid, Moderate Needs Group an individual must:

1. Be a Vermont resident aged 18 or older who meets both clinical and financial eligibility criteria;
2. Have a functional limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging.

B. Individuals NOT eligible for the “Choices for Care”, VT Long-Term Care Medicaid program are individuals who:

1. Do not meet all of the above criteria, or
2. Have a need for Moderate Needs services that can be effectively met with existing Medicare, Medicaid, VHAP, VA or private insurance covered services. (e.g. Home Health Agency services, Day Health & Rehab, CRT, TBI waiver, DD waiver, ASP, etc.)

II. Clinical Eligibility

A. Individuals shall receive eligibility screening by a case manager as the initial step in eligibility determination for the Moderate Needs Group. Individuals who meet any of the following clinical eligibility criteria, as determined by the Department, shall be clinically eligible for the Moderate Needs Group:

1. Individuals who require supervision or any physical assistance three (3) or more times in seven (7) days with any single ADL or IADL, or any combination of ADLs and IADLs.
2. Individuals who have impaired judgment or decision-making skills that require general supervision on a daily basis.
3. Individuals who require at least monthly monitoring for a chronic health condition.
4. Individuals whose health condition shall worsen if services are not provided or if services are discontinued.

III. Financial Eligibility

A. Eligibility

The Department for Disabilities, Aging and Independent Living (the Department) shall find individuals financially eligible for the Moderate Needs group if they meet the criteria below. Post –eligibility rules related to transfer of assets and patient share shall not apply to individuals enrolled in the Moderate Needs Group.

1. Income

- i. Countable Income is all sources of income, including Social Security, SSI, retirement, pension, interest, VA benefits, wages, salaries, earnings and rental income, whether earned, unearned.
- ii. Income Eligibility Standard: The income standard for the Moderate Needs group is met if the adjusted monthly income of the individual (and spouse, if any) is less than 300% of the supplemental security income (SSI) payment standard for one person (or couple) in the community after deducting recurring monthly medical expenses (including but not limited to prescriptions, medications, physician bills, hospital bills, health insurance premiums, health insurance co-pays, medical equipment and supplies, and other out of pocket medical expenses.).

2. Resources

- i. Countable Resources: Countable resources includes cash, savings, checking, certificates of deposit, money markets, stocks, bonds, trusts or other liquid assets, excluding primary residence or one car, that an individual (or couple) owns and could easily convert to cash to be used for his or her support and maintenance, even if the conversion results in the resource having a discounted value.
- ii. A \$10,000 disregard is applied as an adjustment to resource limits.

3. SSI Eligibility Rules

If there is a question about whether or not resources or income are countable under this section, the Department shall apply the SSI-related community Medicaid financial eligibility rules.

B. Coverage

When an individual is found eligible for Moderate Needs services, Choices for Care pays for Moderate Needs services only. Individuals do not automatically become eligible for other Vermont Medicaid health benefits. Individual must apply and be found eligible to receive other Vermont Medicaid benefits.

Individuals who meet the financial and clinical eligibility requirements shall be enrolled in the Moderate Needs group according to the enrollment process specified in this manual.

NOTE: Contact the local DCF office for more information regarding Community Medicaid health benefits eligibility and coverage.

SECTION III. Universal Provider Qualifications & Standards

A. Definition

A “provider” of services for the “Choices for Care”, Vermont Long-Term Care Medicaid program is defined as any entity that has been authorized by the Vermont Agency of Human Services, Department of Disabilities, Aging and Independent Living to provide, and be reimbursed by the State for CFC services as outlined in this manual.

B. Provider Qualifications

All CFC providers must:

1. Be authorized by the Vermont Department of Disabilities, Aging and Independent Living (DAIL) to provide CFC services; and
2. Demonstrate compliance with provider standards, including applicable Federal and State regulations; and
3. Maintain an up-to-date Provider Agreement with DAIL, if applicable; and
4. Be enrolled with Electronic Data Systems (EDS) as a Vermont Medicaid provider.

C. Provider Standards

All provider agencies shall:

1. Comply with all applicable provider qualifications and provider standards.
2. Provide applicable services according to service principles, definitions, standards, approved activities, and limitations.
3. Provide services in a cost-effective and efficient manner, preventing duplication of services, unnecessary costs, and unnecessary administrative tasks.
4. Provide a volume of services at a rate that ensures individuals will maintain services throughout the course of the service authorization period.
5. Budget Moderate needs funding to ensure all Moderate Needs participants are served through the Moderate Needs funding period.
6. Ensure that all staff with direct participant contact have passed a background check as described in the DAIL Background Check Policy.
7. Implement structured internal complaint and appeals procedures.

8. Fully inform individuals of their rights and responsibilities in working with the agency, including both internal and formal waiver complaint and appeal procedures.
9. Encourage and assist the participant to direct as much of her/his own care as possible.
10. Implement policies and procedures that will be used to supervise and/or monitor services.
11. Follow Vermont statute 33 V.S.A. § 6903 regarding mandated reporting of abuse, neglect, and exploitation.
12. Maintain all financial records in accordance with Generally Accepted Accounting Principles (GAAP) seven (7) years.
13. Maintain all records pertaining to delivery and documentation of Medicaid Waiver services for a minimum of three (3) years.
14. Demonstrate to the DAIL that they have sufficient expertise and capacity to meet the needs of the target population, including effective working relationships with other local or regional providers and agencies.
15. Ensure services are provided as defined in the operation protocol manual.
16. Ensure that staff have the skills and/or training required to meet the needs of the participant.
17. Maintain accurate and complete documentation of services provided to the individual.
18. Report any concerns about services or the individual's status and condition to the individual's Choices for Care case manager.
19. Ensure that the volume of services and rate charged to the State are based on services actually provided to the participant, within the service limits.
20. Avoid conflicts of interest between the interests of the individual and the interests of the provider and its staff.
21. Assist the State in ensuring that services are provided in compliance with the standards, policies and procedures established by the State. This includes participating in structured evaluation activities developed by the State.
22. Abide by principles of confidentiality and all applicable confidentiality policies and laws.

23. Comply with all applicable laws and regulations regarding employment, including the provision of workers compensation insurance and unemployment insurance to employees.

SECTION IV. Moderate Needs Group Services

A. Choices for Care Moderate Needs Group services include:

1. Case management
2. Homemaker service
3. Adult Day
4. Flexible Funding

NOTE: Refer to specific manual section for detailed service definitions and limitations.

B. Principles

1. Choices for Care services foster respect, dignity, and a sense of well being for the individual being served.
2. Choices for Care services respect individual rights, strengths, values, privacy, and preferences, encouraging individuals to direct and participate in their own plan of care and services to the fullest extent possible.
3. Choices for Care services respect individual self-determination, including the opportunity for individuals to decide whether to participate in a program or activity.
4. Choices for Care services are provided as part of a comprehensive and individualized plan of care, which is developed through collaboration to meet the needs of the individual. All Choices for Care services are coordinated with other services.
5. Choices for Care services are provided in an efficient manner, preventing duplication of services, unnecessary costs, and unnecessary administrative tasks. Long Term Care Medicaid services attempt to use resources efficiently to maximize the benefits and services available to all individuals.
6. Choices for Care services will not be used to secure improper or inappropriate gain for the provider, provider staff, family members or any other person involved in the individual's care.

C. Desired Outcomes

1. The individual continues to reside in his/her setting of choice.
2. The individual's needs are met, and he or she is as healthy as possible.
3. The individual's optimal level of functioning and independence is achieved or maintained.
4. The individual is satisfied with services.

5. If applicable, primary caregivers receive relief from care giving responsibilities, as well as education and support, and continue to provide care.
6. If applicable, the individual's primary caregiver or family is satisfied with services.
7. Services are provided in an efficient manner, and duplication of effort and services is minimized.
8. Services are provided in a manner to prevent inappropriate institutionalization.

SECTION IV. 1. Case Management Services

A. Definition

“Case Management Services” assist individuals in gaining access to needed Choices for Care services as well as other medical, social, and educational services, regardless of the funding source for the services to which access is gained. Case Management Services provide detailed needs assessment and assist the individual in creating a comprehensive plan. Case Management Services provide ongoing assessment and monitoring. Case Management Services assist the Department of Disabilities, Aging and Independent Living (DAIL) in monitoring the quality, effectiveness and efficiency of services.

B. Case Management Standards

1. Case Management providers shall be authorized by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:
2. DAIL Case Management Standards & Certification Procedures
3. Universal Provider Qualifications and Standards (Section III.)
4. Services Principles (*Section IV.B*)

C. Provider Types

The following provider types are approved to provide Case Management Services when authorized by DAIL:

1. Area Agencies on Aging
2. Home Health Agencies as defined by State statute

D. Approved Activities

Case Management Services includes the following reimbursable activities:

1. Assessment: A comprehensive review of the individual circumstances, including, but not limited to, social, medical, functional, financial and environmental needs.
2. Care-Planning: A formal process of identifying the needs of the individual as identified in the assessment process. A plan is then developed to meet the identified needs and services to be delivered.
3. Service Coordination: The process by which services are obtained for the individual through coordination with multiple resources.

4. Information and Referral: The process by which the individual is fully informed of available options and referrals are made as needed.
5. Monitoring: Ongoing review of individual's status, needs and service utilization at least once every quarter, by phone or face to face, as determined by the individual's needs.
6. Documentation: Documentation includes all required CFC forms, applications for other services or public benefits as needed and the documentation of ongoing case management activities.
7. Travel: Travel time includes getting to and from participant home-visits (or other face-to-face participant visit) and care-planning meetings related to individual service coordination.

E. Limitations

1. Case Management Services are limited to the "approved activities" for individuals authorized by DAIL for Moderate Needs services.
2. Case Management Services are limited to up to 12 hours per individual per calendar year (January-December). Variances may be given, as needed, for a maximum of up to 24 hours per individual per calendar year (January-December). A variance may be requested by sending a written justification to DAIL.
3. Case Management Services may not be delegated to another case manager except under short-term, temporary situations.
4. Case Management Services may be provided and billed for up to 180 days after admission and/or preceding discharge from a nursing facility or hospital, when such services are clearly documented as facilitating the individual's return to the community. Claims for such case management services must be submitted after the actual date of discharge from the hospital or nursing facility, as a single claim.
5. Case Management alone does not qualify someone for Moderate Group. Each Moderate Group participant must receive either Homemaker or Adult Day.

SECTION IV. 2.

Adult Day Services

A. Definition

“Adult Day Services” are community-based non-residential services designed to assist impaired or isolated adults to remain as active in their communities as possible, maximizing their level of health and independence and ensuring the optimal functioning. Services include a range of health and social services for participants and provide daytime respite to primary caregivers. Services are furnished for a specified number of hours per day on a regularly scheduled basis, for one or more days per week.

B. Adult Day Standards

Adult Day providers shall be certified by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:

1. Standards for Adult Day Services in Vermont (DAIL)
2. Universal Provider Qualifications and Standards (*Section II.*)
3. Services Principles (*section IV.B*)

C. Provider Types

The following provider type is approved to provide Adult Day Services when authorized by DAIL:

- Vermont Certified Adult Day Providers

C. Approved Activities

Adult Day Services includes the following approved, reimbursable activities:

1. Assessment
2. Personal Care
3. Therapies
4. Activities
5. Meals
6. Social Outings
7. Nursing Overview
8. Respite

D. Limitations

1. Adult Day Services are limited to up to 50 hours per week per approved individual (as of May 2009).

2. Adult Day Services are limited to a maximum of 12 hours per day.
3. Adult Day Services are limited to the hours of operation and capacity of the adult day provider.
4. Meals provided as part of Adult Day Services shall not constitute a “full nutritional regimen” for the day.
5. Transportation services are not included and are not reimbursed as part of Adult Day Services. The costs of transporting participants to and from the Adult Day Services site may be eligible for reimbursement under the Medicaid State Plan, as a transportation service.
6. Adult Day Services shall not be reimbursed for individuals residing in a licensed facility (hospital, nursing facility, residential care home, assisted living residence).

SECTION IV. 3. Homemaker Services

A. Definition

"Homemaker Services" means certain activities that help to maintain a safe, healthy environment for individuals residing in their homes. Such services contribute to the prevention, delay, or reduction of risk of harm or hospital, nursing home, or other institutional care.

B. Homemaker Standards

Homemaker providers shall be approved by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:

1. Standards for Homemaker Services in Vermont (DAIL)
2. Universal Provider Qualifications and Standards (*Section II.*)
3. Services Principles (*Section IV. B.*)

C. Provider Types

The following provider type is approved to provide Homemaker Services when authorized by DAIL:

- Designated Home Health Agencies

C. Approved Activities

Homemaker Services includes the following approved, reimbursable activities:

1. Supportive Services (shopping and errands essential to maintain living quarters); and/or
2. Home management services (cooking, cleaning, laundry, and related light and heavy housework)
3. Assessment

D. Limitations

1. Homemaker Services are limited to up to 6 hours per week per approved individual.

SECTION IV. 4. Flexible Funding

A. Definition

"Flexible Funding" is the flexible use of Moderate Needs funds to pay for services that contribute to the prevention, delay, or reduction of risk of harm or hospital, nursing home, or other institutional care.

B. Flexible Funding Standards

Flexible Funding shall be managed through the participant's Certified Case Management Agency. Agencies are approved by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:

1. DAIL Case Management Standards & Certification Procedures
<http://www.ddas.vermont.gov/ddas-programs/programs-oaa/programs-oaa-cm>
2. Universal Provider Qualifications and Standards (*Section II.*)
3. Services Principles (*Section IV. B.*)

C. Provider Types

The following DAIL certified Case Management provider types are approved to manage and submit claims for Moderate Needs Flexible Funding (revenue code 079):

- Area Agency on Aging
- Designated Home Health Agencies

C. Approved Services

Flexible Funding services are managed and billed through the participant's case management agency.

Examples of services eligible for purchase through a Flexible Funding budget:

1. **Self-Hired Attendant**: Participants (or their surrogate) who are able and willing to hire their own attendant may self-hire an employee to provide homemaker, personal care, respite or companion services. The case manager works together with the participant to determine how much assistance they require and the rate at which they will pay their workers. The participant or their surrogate is responsible for training, supervision and scheduling. Payment for self-hired assistance will be coordinated through the case management agency to the state contracted Intermediary Services Organization (ISO). The budgeted cost of self-hired assistance will include the total costs of employee wages, taxes, worker's compensation insurance, unemployment insurance and ISO services.

2. Intermediary Services Organization (ISO): Participants who choose to self-hire attendant services must do so through the state contracted ISO. Payment to the ISO for services is managed by the case management agency and is included in the participant's maximum funding limit. The ISO manages all payroll services including background checks.
3. Goods & Services: Examples of Goods & Services include, but are not limited:
 1. Personal Emergency Response Services (PERS)
 2. Assistive Devices (e.g. grab bars)
 3. Home Modifications (e.g. ramp, widened doorway)
 4. Home goods or appliances that support the person in their ADLs or IADLs
 5. Transportation for non-Medicaid eligible participants
 6. Interpreter services for non-Medicaid eligible participants
 7. Personal Care, Respite, Companion.
4. Agency Administrative Fee: Case management agencies are responsible for receiving vendor invoices, processing payments to vendors based on the participant's flexible funding budget and reporting these payments to DAAIL by the 15th of each month on an excel report form. A copy of the vendor invoice must be maintained by the case management agency.

Case management agencies may submit a Flexible Funds claim for administrative fees to cover the cost of billing/vendor payment services. The fee is up to \$25/month for each person the agency provides billing/vendor payment services to in one month and is reflected on the monthly report to DAAIL. The administrative fee must be included in the participants' flexible funding budget and comes directly from the case management agencies Moderate Needs allocation cap.

D. Limitations

1. Flexible Funding is limited to a budget of \$3,500 per person per calendar year. Case Management agencies may grant additional funds on a case by case basis when there is no wait list for Moderate Needs services in their region and the purchase meets the Flexible Funding definition and standards.
2. Flexible Funding may not be used to purchase services covered by the participant's health insurance benefit.
3. Flexible Funding may not be used to purchase illegal services.
4. Flexible Funding services provided through a designated or licensed agency must follow all applicable federal and state regulations.
5. Services purchased through a Vermont Medicaid vendor must be billed at the Medicaid rate on file.
6. All employee wages must be paid at or above the Vermont minimum wage standards and below the maximum market rate. Minimum wage information can be found at <http://www.dol.gov/whd/minwage/america.htm>.

7. Assistive devices and home modifications must comply with all applicable medical and manufacturing standards and State and local building codes.
8. Employees providing assistance to participants must pass a background check as described in the DAIL Background Check Policy.
9. Flexible Funding shall not be used to purchase dentures, eye glasses or rent/room & board.

SECTION V.1. Application, Screening, Eligibility Determination & Reinstatement Procedures

A. Application Procedures

1. Department of Disabilities, Aging and Independent Living (DAIL) staff shall make Choices for Care information available to all individuals, local agencies, and organizations.
2. Application may come from any source.
3. Moderate Needs applications must be completed, signed by the individual or legal representative and sent to the certified Case Management Agency (Home Health Agency – HHA or Area Agency on Aging – AAA) as identified on the Moderate Needs application form.

B. Initial Screening Procedures

1. Verify Funding: The Moderate Needs case manager (CM) will verify funding available for the services requested on the application and contact the individual within 3 working days of receipt of the Moderate Needs application.
2. No Funding: If funding is not available for the requested service(s), the CM will do a telephone screening to verify the need for Moderate Needs services, clinical and financial eligibility. The CM will inform the individual that there is a waiting list and will give the individual the option of being placed on the waiting list. The CM will determine if follow-up is needed and take necessary action to assist the individual in obtaining other services.
3. Funding for one service only: If the individual needs both HMK and AD services, yet funding is available for only one service, the CM will continue the eligibility process for the service for which funding is available and send a wait list notice to the individual and provider of the other service. When funds become available, the CM will send a Moderate Needs Group Change form to DAIL Moderate Needs Coordinator to add the new service.
4. Funding Available: If funding is available, the CM will arrange for a face-to-face visit to continue the eligibility process.

C. Eligibility Procedures

1. Clinical Screening: At the face-to-face visit, the CM will complete the Permission to Release Information, Independent Living Assessment (ILA) Intake (short version) and screen for clinical eligibility using the Moderate Needs Group Clinical Eligibility worksheet.
2. Financial Screening: If the applicant appears to meet the Moderate Needs Group clinical criteria, the CM will complete the Moderate Needs Group Financial Eligibility Worksheet.

3. If the applicant meets both the clinical and financial criteria, and there is funding to serve the individual, the CM will send the following complete application packet to both the Moderate Needs Coordinator at the DAIL Waterbury office and the Moderate Needs Providers:
 - a. Moderate Needs application,
 - b. ILA Intake,
 - c. Clinical Worksheet,
 - d. Financial Worksheet, and
 - e. Complete Package Checklist.

NOTE: DAIL will return all incomplete application packets to the case manager.

4. **Eligibility Determination:** The Moderate Needs Coordinator will review the clinical and financial information for accuracy and eligibility determination.
5. **Notifications:** If found clinically and financially eligible for Moderate Needs Group services, the Moderate Needs Coordinator will complete and send the Moderate Needs Group Service Authorization to the applicant, provider(s) and the Department for Children and Families (DCF).
6. **Start Date:** The effective start date for Moderate Needs services shall be the date the applicant signed the Moderate Needs applications, the date the applicant was taken off the wait list or a later date as requested by the CM. For individuals coming off the Moderate Needs wait list, the CM will write the date the individual came off the wait list on the top of the application.
7. **Ineligibility:** If during the screening process the CM believes an applicant is not eligible, the CM will send all information to the Moderate Needs Coordinator. Moderate Needs Coordinator will review the application package and make an eligibility determination. If the applicant is not eligible, Moderate Needs Coordinator will send the applicant a written notice of denial including appeal rights.

D. Wait List Procedures

1. If funding is not available and the applicant chooses to be placed on a waiting list, the CM will notify the applicant in writing and will send a copy of the notice and application to the requested service providers.
2. The CM and Moderate Needs Providers will follow the Waiting List Procedures in Section V.2. of this manual.

E. Reinstatement

When a provider suspends a participant for 60 days or less, due to a Medicaid-funded stay at a rehabilitation facility or nursing home and they wish to reinstate the participant, they must complete only the Application & Reassessment form. This completed form must be forwarded to the Moderate Needs Group Coordinator and service providers.

F. Other Services

Together with the individual, the CM will assess and arrange for other services as necessary to meet the identified needs of the individual. If the individual is placed on a waiting list, the CM will determine if other follow-up is needed and take necessary action to assist the individual in obtaining other appropriate services.

SECTION V.2. Waiting List Procedures

Choices for Care Moderate Needs applicants may be placed on a waiting list if funds are not available or capacity at Adult Day is not available at the time of application, using the following procedures:

1. If funding, or capacity at Adult Day, is not available at time of application, the case manager (CM) will notify the individual in writing and will send a copy of the notice and application to the requested Service Providers.
2. The Homemaker Agency or Adult Day provider (Moderate Needs Providers) will place the individual on their waiting list.
3. Applicants on Community Medicaid are considered first priority, then chronological order by date of application.
4. Participants who are already active on Moderate Needs and wish to add a second service will be put on the wait list according to their original Moderate Needs application date (*See Section V.3 Changes & Reassessment Procedures*).
5. The wait list should contain only those people who are still waiting for funding on the last day of the reporting month.
6. The wait list shall not contain the names of people who have an active Moderate Needs service authorization and are waiting for staffing or additional hours. (*See Section III Universal Provider Standards*).
7. The Moderate Needs Providers must forward a copy of the wait list to DAIL by the 15th of the month following the reporting month. *For example, the January report is due at DAIL by February 15th and must contain everyone waiting for funding as of January 31st.*
8. Providers who have no wait list must either send a blank wait list or send an email to DAIL by the 15th of the month stating they have no wait list.
9. When funding is allocated to an applicant the Moderate Needs Providers will indicate such date on the wait list and notify the Moderate Needs case manager.
10. The CM will notify the applicant when funding becomes available and continue the eligibility process. The CM shall put the date the applicant came off the wait list on the Moderate Needs application.
11. If the individual is already receiving other Moderate Needs services, the CM will complete a Moderate Needs Group Change Form and send to the Moderate Needs Coordinator. The Moderate Needs Coordinator will complete and send a new Service Authorization to the individual, case manager and provider(s).

12. The effective date of the service will be the date the individual was taken off the wait list or a later date as requested by the CM.
13. The DAIL Moderate Needs Coordinator will review the provider's wait list upon receiving a new Moderate Needs application to ensure that Medicaid applicants are served before non-Medicaid applicants.
14. Providers must assure that all people listed on their wait list are still waiting for funding to be served. This is accomplished contacting people on the wait list at least once every six months.

SECTION V.3. Change & Reassessment Procedures

A. Change Procedures

1. **Adding a Service:**
 - a. When a person needs to add a new Moderate Needs service, the person's case manager must first contact the new provider to verify funding availability.
 - b. If funds are confirmed available, the case manager will make a referral to the new agency and send a Moderate Needs Change Form to DAIL program manager.
 - c. If funds are not available to add the new service, the case manager must send a copy of the original Moderate Needs application to the new Moderate Needs Service provider with a request to add the person to their Moderate Needs Wait List. *Note that the person does NOT need to complete a new Moderate Needs application.*
 - d. The provider will then add the person's name to their wait list based on the original application date and whether they have Community Medicaid.
2. **Other Changes:** If the individual has a change of address, a change of provider or is removing a service from the Service Authorization, the CM will complete a Moderate Needs Group Change Form and send to the Moderate Needs Coordinator within 10 working days of the change.
3. The Moderate Needs Coordinator will review the Change Form and send the authorize Change Form to the applicant, CM and provider(s) as needed.
4. **Start Date:** The effective start date to add a service will be the date the Moderate Needs Change Form was received at DAIL or a later date as indicated by the CM on the form. The effective date to remove a service or to change an address or provider will be the date the change took effect.
5. **Retroactive Services:** If retroactive services are requested, the CM must submit a request for an exception with a description of the need. DAIL approval for retroactive services is not guaranteed.
6. **Change in Clinical or Financial Status:** If the CM believes the individual no longer meets clinical or financial eligibility, the CM shall complete and submit revised supporting documents to both the Moderate Needs Providers and the Moderate Needs Coordinator. The Moderate Needs Coordinator will review for eligibility and send a termination notice with appeal rights to those who are no longer eligible.

B. Reassessments Procedures

1. Individuals participating in CFC Moderate Needs services must have a reassessment completed on an annual basis.
2. Approximately 4 weeks prior to the end date of the Moderate Needs Group Service Authorization, the CM will complete the ILA (short version), the Permission for Release of

Information, the clinical eligibility worksheet, financial eligibility worksheet, and complete package checklist.

3. The CM will submit the following complete reassessment packet to both the Moderate Needs Coordinator and Moderate Needs provider(s) so that it is received no later than 15 days prior to the end date of the Moderate Needs Group Service Authorization:
 - a. Moderate Needs Group Annual Reassessment form,
 - b. ILA Intake,
 - c. Permission to Release Information,
 - d. Clinical Worksheet,
 - e. Financial Worksheet, and
 - f. Complete Package Checklist
4. The Moderate Needs Coordinator will review for eligibility and if the individual continues to meet the eligibility requirements, will send a Moderate Needs Group Service Authorization to the individual and the Moderate Needs providers.
5. If the Moderate Needs Coordinator determines that the individual no longer meets the criteria for eligibility they will send a denial notice with appeal rights to the individual and notify Moderate Needs providers.

IMPORTANT: Individuals with an overdue annual reassessment are at risk of being involuntarily terminated from Moderate Needs services. Providers must have a current Service Authorization in order to bill for services provided. All overdue reassessments must be accompanied with an explanation of the reason for being overdue.

C. Monitoring

Case managers shall monitor the individual's status, needs and service utilization at least once every quarter, by phone or face to face, as determined by the individual's needs.

SECTION V.4.

Initiating Services Procedures

A. Initiating Services

1. The Case Manager (CM) shall coordinate the initiation of services, as funding is available, with the Moderate Needs Providers.
2. If it appears to the CM that the applicant will meet clinical and financial criteria, and funds and capacity, are available, then services may start prior to receipt of the Service Authorization from the Moderate Needs Coordinator.
3. CM shall inform applicants that by starting services in advance of final DAIL Service Authorization, the individual will be liable for payment of services provided if they are subsequently found ineligible for Moderate Needs services.
4. The provider and applicant may delay the initiation of Moderate services until the Moderate Needs Coordinator has determined Moderate Needs eligibility and has authorized services.
5. The provider shall not bill Electronic Data Services (EDS) for Moderate Needs services provided until the provider has received an authorization from the Moderate Needs Coordinator through an approved Service authorization form (CFC MOD 904).
6. If the Moderate Needs Coordinator determines the individual does not meet the eligibility criteria for Moderate Needs services, the provider may bill the individual for services provided, if an agreement for payment was made with the individual prior to providing services, and as long as the services provided are not reimbursable under other applicable insurance options (e.g. Medicare or private insurance).

SECTION V.5.

Withdrawal, Denial, and Termination Procedures

A. Voluntary Withdrawal

An applicant may voluntarily withdraw her/his application for Choices for Care (CFC) Moderate Needs services or participation in Moderate Needs services at any time for any reason using the following procedures:

1. The individual shall inform the Case Manager (CM) of her/his decision to withdraw from Moderate Needs services.
2. A Moderate Needs Withdrawal/Termination form must be completed by the case manager and sent to other Moderate Needs providers and the Moderate Needs Coordinator indicating the reason for termination. This form will be submitted within 10 calendar days of the date of withdrawal or termination of services.
3. For Moderate Needs participants withdrawing from services, Moderate Needs Coordinator will forward a copy of the Withdrawal/Termination Notice to DCF Central Office.
4. For individuals who wish to suspend services for 60 days or less due to a Vermont Medicaid-funded stay at a nursing or rehabilitation facility with the intent of returning to the Moderate Needs program, the provider may choose to suspend services. They must follow the Reinstatement Procedures located in Section V.1.

B. Denials and Terminations

New applicants may be denied eligibility and active participants may be terminated from Moderate Needs services for the following reasons:

1. Clinical ineligibility: The CM will screen the applicant for clinical eligibility using the ILA Intake and Clinical Eligibility Worksheet. If the applicant does not meet the eligibility criteria the CM will send all necessary information to the Moderate Needs Coordinator. Moderate Needs Coordinator shall review the information and if the applicant is determined to be ineligible, Moderate Needs Coordinator will send the applicant a written notice with appeal rights.

If the provider believes the applicant is clinically eligible and Moderate Needs Coordinator determines that the applicant is clinically ineligible, Moderate Needs Coordinator will send the applicant a notice with appeal rights and copy the CM and providers.

2. Financial ineligibility: The CM will screen the applicant for financial eligibility using the Financial Eligibility Worksheet. If the applicant does not meet the eligibility criteria the CM shall send the Moderate Needs Coordinator all necessary information. Moderate Needs Coordinator shall review the information and if the applicant is

determined to be ineligible, Moderate Needs Coordinator will send the applicant a written notice with appeal rights.

If the CM believes the applicant is financially eligible and Moderate Needs Coordinator determines that the applicant is financially ineligible, Moderate Needs Coordinator will send the applicant a notice with appeal rights and copy the CM and providers.

Moderate Needs services and/or participation will be terminated under the following circumstances:

- Participant death
- Permanent move out of state
- Temporary stay out of state-exceeding 60 continuous days
- Provider termination of services: In limited situations, a Moderate Needs provider may terminate services for the following reasons:
 - i. Dangerous environment placing staff at risk of harm.
 - ii. Behaviors in a group environment that are not easily alterable and are disruptive to the group.
- Participant enrolling onto Choices for Care High or Highest Needs Group
 - i. This date must coordinate with the DAIL Long Term Care Clinical Coordinator's service plan start date. *This will be the day before the High or Highest Needs Group Service Plan begins.*

It is expected that the provider will make all reasonable attempts to remedy the situation prior to termination of services. Efforts may include, but are not limited to, negotiated risk contracts, involvement of Adult Protective Services, family care conferences, and interdisciplinary team meetings. Efforts must be clearly documented and the provider must contact Moderate Needs Coordinator and the case manager (when applicable), prior to termination. Once a decision to terminate services has been made, the provider must send a written notice to the individual and Moderate Needs Coordinator explaining the reasons for termination. Providers must follow their Agency policies or regulations when terminating services.

If **the provider** has terminated services and the individual is **not** receiving other Moderate services (excluding case management) the individual will be terminated from Moderate Needs services 30 days after services were ended. The provider must consult with Moderate Needs Coordinator and CM prior to termination. A "Moderate Needs Withdrawal/Termination" must be completed by the Case Manager and sent to Moderate Needs Coordinator and all service providers. Moderate Needs Coordinator will forward a copy of the form to DCF Central Office staff.

SECTION V.6.

Appeals Procedures

I. Appeals

An individual may request a Commissioner's hearing, a fair hearing before the Human Services Board, or both. An appeal may be made to the Commissioner and the Human Services Board at the same time. An appeal may also be made to the Human Services Board following a Commissioner's hearing.

A. Commissioner's Hearing

1. An **applicant or participant, or his or her legal representative**, who wishes to appeal a decision regarding clinical eligibility, financial eligibility or termination of eligibility, may request a formal review of that decision by the Commissioner of the Department.
2. The request for a Commissioner's hearing may be made orally or in writing, and shall be made within thirty (30) days of receiving written notice.
3. A request for a Commissioner's hearing shall be made by calling or writing to:

Commissioner's Office
Department of Disabilities, Aging & Independent Living
103 South Main Street
Waterbury, VT 05671-1601
802-241-2401

4. The **Commissioner** shall send written notice of the decision, with appeal rights, to the applicant or participant within thirty (30) days of the completion of the hearing.

B. Fair Hearing

An **applicant or participant, or his or her legal representative**, may file a request for a fair hearing with the Human Services Board. An opportunity for a fair hearing will be granted to any individual requesting a hearing because his or her claim for assistance, benefits or services is denied, or is not acted upon with reasonable promptness; or because the individual is aggrieved by any other Department action affecting his or her receipt of assistance, benefits or services; or because the individual is aggrieved by Department policy as it affects his or her situation. The Department shall respond to any clear indication (oral or written) that an applicant or participant wishes to appeal by helping that person to submit a request for a hearing.

1. An **applicant or participant, or his or her legal representative**, who wishes to appeal a decision of the Commissioner or any decision regarding clinical eligibility, financial eligibility or termination of eligibility, may request a fair hearing with the Human Services Board.

2. The request for a fair hearing must be made within ninety (90) days of receiving the written notice of determination or the written notice of the decision of the Commissioner.
3. A request for a fair hearing shall be made to:

Human Services Board
120 State Street
Montpelier, VT 05620-4301
802-828-2536

C. Continuation of Services Pending Appeal

1. Moderate Needs services shall not be provided to new applicants during the appeals process.
2. Moderate Needs services may continue to be provided to enrolled participants during the appeals process.
3. In order to continue to receive services, enrolled participants must request continued services when submitting the appeal. Choices for Care services shall be discontinued on the effective date of the decision unless the appeal is requested as of the effective date of the decision. In no event shall the effective date occur on a weekend or holiday.
4. Continuation of services does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require advance notice.

D. Adverse Action

When a **DAIL** decision will end the services an individual has been receiving, the notice of decision shall be mailed at least eleven (11) days before the decision will take effect, except when:

1. **DAIL** has facts confirming the death of the individual;
2. **DAIL** has facts confirming that the individual has moved to another state;
3. **DAIL** has facts confirming that the individual has been granted Medicaid in another State;
4. The individual has been admitted to a facility or program that renders the individual ineligible for services;

5. The Department receives a statement signed by an individual that states that he or she no longer wishes services; or
6. The individual's whereabouts are unknown and the post office returns agency mail directed to him or her indicating no forwarding address.

SECTION V.7. Provider Enrollment and Billing Procedures

A. Provider Enrollment

All Choices for Care (CFC) providers must enroll as a Medicaid provider in the Medicaid claims processing system via Electronic Data Systems (EDS). The following procedures should be used to enroll CFC providers:

1. The interested agency or organization must contact the Department of Disabilities, Aging and Independent Living (DAIL) CFC administration to request DAIL authorization to provide specific CFC services. The interested provider must submit the following information to DAIL in writing:
 - The name of the provider agency or organization
 - The address, phone number, and fax number of the agency or organization
 - Contact person in the agency or organization (for purposes of discussing provider eligibility and provider enrollment)
 - Requested effective date of Medicaid Waiver provider status
 - The service(s) which the agency or organization would like to provide
 - The area(s) in which the service will be provided
2. DAIL may contact the agency or organization to request additional information, and may visit the agency or organization prior to approving or denying the request.
3. If DAIL denies the request, DAIL will communicate this in writing to the organization.
4. If DAIL authorizes the request, DAIL will send an authorization to EDS, the Department for Children and Families (DCF), and the agency or organization, including the following:
 - The name of the provider agency or organization
 - The address, phone number, and fax number of the agency or organization
 - Contact person in the agency or organization (for purposes of provider enrollment)
 - The requested effective date of Medicaid Waiver provider status
 - The service(s) which the agency or organization is authorized to provide
5. CFC providers must obtain applicable sections of the CFC Protocol Manual, brochures and forms (when applicable).
6. EDS Provider Enrollment and Recertification staff (802-879-4450) will assure that the provider has completed a Medicaid provider enrollment agreement and is enrolled as a CFC provider.
7. Any problems or obstacles in provider enrollment will be addressed by negotiation between EDS, DAIL, and the potential service provider.

B. Claims

1. CFC service providers shall only submit claims for reimbursement for services that have been

provided to eligible individuals in compliance with applicable service definitions, provider qualifications, and standards.

2. CFC service providers shall submit all claims for CFC services through Vermont's Medicaid Management Information System (MMIS), managed by Vermont's Medicaid fiscal intermediary, Electronic Data Systems- (EDS), in accordance with CFC and EDS procedures. Questions about CFC service claims, payments, and claims procedures should be addressed to EDS (802-879-4450).
3. CFC service providers shall have mechanisms or procedures to assure that claims which are submitted are accurate, and in compliance with all applicable procedures and regulations.
4. CFC service providers are responsible for preparing and submitting claims for services that they provide.
5. CFC service providers shall submit claims using the correct revenue code, as described in the following table.
6. CFC service providers must have a current Moderate Needs Service Authorization approved by DAIL before any claim for CFC Moderate Needs services may be submitted to (Electronic Data Systems [EDS]). Providers shall not bill for services provided after the end date of an expired, overdue Service Authorization.
7. CFC service providers must obtain and retain copies of the DAIL approved Moderate Needs Service Authorization for every Moderate Needs Group participant to whom CFC services are provided.
8. If a CFC service provider submits any claims for any CFC services that exceed the dates, types and/or amounts of services that are authorized by DAIL on the Moderate Needs Service Authorization, the service provider must arrange recoupment (or re-payment) to EDS of any payments for services that exceed the dates, types and/or amounts authorized.
9. If a CFC service provider submits any claims for any CFC services which exceed the types and amounts of services actually provided to an eligible individual (but are within the dates, types and amounts of services which are authorized by DAIL), the service provider must arrange recoupment (or re-payment) to EDS of any payments for services which exceed the amount actually provided.
11. Case Management services may be provided and billed for up to 180 days after admission and/or preceding discharge from a nursing home or hospital, when such services are clearly documented as facilitating the individual's return to the community. Claims for such case management services must be submitted after the actual date of discharge from the hospital or nursing home, as a single claim.
12. CFC Moderate Needs provider reimbursement, in addition to Moderate Needs service limitations, reimbursement is limited to a set dollar amount per State fiscal year, (7/1-6/30) per provider, established by DAIL.

SECTION V.8. Complaint Procedures

Complaints are a valuable aspect of quality improvement. Individuals have the right to make a complaint regarding any aspect of the “Choices for Care” (CFC), Medicaid program.

In general, the Department of Disabilities, Aging and Independent Living (DAIL) encourages complaints and conflicts to be resolved at the local level whenever possible. Complaints may be made to DAIL verbally, by telephone, or in writing. DAIL staff will respond in a courteous, timely, and professional manner to all complaints, and will document all complaints which are referred to DAIL for resolution.

A. Procedures

All CFC provider agencies are required to have a complaint procedure that addresses how complaints will be collected and resolved internally. In general, the following procedures apply:

1. If a complaint arises, the individual or their case manager (if applicable) should be encouraged to contact the provider agency directly to resolve the issue.
2. If the individual is unable to resolve the issue, the individual or their case manager (if applicable) may contact the Department of Disabilities, Aging and Independent Living (DAIL).
3. DAIL staff shall document the complaint and discuss possible means of addressing the complaint with the individual, their case manager (if applicable), and the person/provider against whom the complaint was made.
4. DAIL staff shall document any actions, investigations, and/or results associated with the complaint.
5. DAIL staff will send a brief written summary of the result of the investigation to the complainant.
6. DAIL staff will send a written summary of the result of the investigation to the person/provider against whom the complaint was made. This shall include a plan of correction if necessary.

B. Long-Term Care Ombudsman

The Vermont Long-Term Care Ombudsman Program helps resolve complaints for individuals receiving CFC services. Individuals, case managers, providers may contact the Ombudsman by calling Vermont Legal Aid at 1-800-917-7787.

C. Division of Licensing and Protection (DLP)

DAIL staff shall forward the following types of complaints to the Division of Licensing and Protection for investigation and resolution:

1. Suspicion of Abuse, Neglect or Exploitation shall be forwarded to Adult Protective Services within 48 hours. (800-564-1612 or 802-241-2345)
2. Issues related to Home Health Agency Medicare and Medicaid certification (i.e.: skilled nursing services, LNA, PT, OT, MSW).
3. Issues related to Nursing Facility, Residential Care Home, or Assisted Living Residence licensing regulations.

All mandated reporters are required by law to report suspected abuse, neglect of exploitation to DLP.

Individuals, case managers or providers may contact DLP for assistance by calling (800)-564-1612 or 802-241-2345.

D. Medicaid Fraud

Medicaid fraud is committed when a Medicaid provider is untruthful regarding services provided to the participant in order to obtain improper payment. The Medicaid Fraud and Residential Abuse Unit of the Vermont Attorney General's Office investigates and prosecutes people who commit fraud against the Medicaid program.

Examples of Medicaid fraud include, but are not limited to:

1. Billing for services not actually provided (e.g. signing or submitting a timesheet for services which were not actually provided).
2. Billing for services provided by a different person (e.g. signing or submitting a timesheet for services provided by a different person).
3. Billing twice for the same service (e.g. signing or submitting a timesheet for services which were reimbursed by another source, or signing or submitting a duplicate timesheet for reimbursement from the same source).

DAIL staff shall refer suspected cases of Medicaid fraud to the Attorney General's Medicaid Fraud Control Unit for investigation and resolution. In addition, DAIL staff may also refer the case to the local police authorities for further investigation and possible prosecution.

Individuals, case managers or providers may contact the Medicaid Fraud unit for assistance by calling (802) 241-4440.

SECTION V.9

ICD-10 Code Policy & Procedures

(For obtaining codes prior to October 1, 2015)

A. Policy

All Choices for Care (CFC) Moderate Needs participants must have a billable ICD-10 diagnosis code that relates to their need for moderate need services.

The Case Manager shall obtain and record the ICD-10 code on all Moderate Needs Group Service Request and Authorization form.

B. Definition

ICD-10 replaces the ICD-9 code sets and includes updated medical terminology and classification of diseases.

ICD-10 codes are a method of coding an individual's state of health and institutional procedures. ICD-10 codes provide more information per code and provide better support for care management, quality measurement and analytics. There is an improved ability to understand risk and severity using these codes.

The detail captured by ICD-10 can facilitate patient care coordination across settings and improve public health reporting and tracking.

ICD codes for the purpose of CFC Moderate Needs Group must be related to the participant's need for moderate need services. This means that the code must match or be closely related to the reason for CFC Moderate Needs functional eligibility. Example: A participant has had a long standing history of cardiac dysrhythmia and high blood pressure, but been experiencing functional limitations resulting from a gradual decline of short term memory. The accurate ICD code would be for vascular dementia.

ICD-9 code = 290.40 Vascular dementia, uncomplicated

ICD-10 code = F501.50 Vascular dementia without behavioral disturbance

For more information visit the Centers for Medicare and Medicaid Services:

http://cms.gov/Medicare/Coding/ICD10/ProviderResources.html?gclid=CjgKEAjwuMmdBRDljdfi2_qQpxkSJADDCRwsZRbXpYFzq0w33xl7g7OBDlyX3yJm02zF0tvFHERWZPD_BwE

C. Procedure

1. Initial Service Request

- A. The Case Manager will ensure that the current ICD-9 code relates to the Individual's need for moderate needs services and will use the code translator to obtain the ICD-10 code, if necessary.

The following sites may be used to look up codes:

- **ICD-9 Look up:** <http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx>
- **ICD-10 code look up:** <http://www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx>

The following site may be used to **translate** codes from ICD-9 to ICD-10:

(This resource is a non-qualified source and providers need to be conscious that it should only be used subjectively) <https://www.aapc.com/icd-10/codes/>

- B. If the Case Manager is unsure what diagnosis and ICD-9 code relates to the individual's need for moderate needs services, then the Case Manager shall contact the participant's primary care physician to obtain an ICD-9 and/or ICD-10 code that relates to their need for services. Some examples: Osteoporosis, Arthritis, Diabetes, Alzheimer's Dementia, Vascular Dementia etc. If the physician has an ICD-9 code, but no ICD-10 code, then the Case Manager can use the ICD-10 code translator.
- C. The Case Manager shall include the ICD-9 and ICD-10 code on the applicable service request and authorization form until the official change to ICD-10 on 10/1/15. After 10/1/15 only an ICD-10 code is needed.
- D. The DAIL Independent Living Services Consultant will enter the ICD-9 and 10 code into the SAMS database in the care plan when doing utilization review and processing the service authorization.

2. Reassessment/Change of Service Request

- A. If there has been a change in an individual's diagnosis related to the need for moderate need services at the time of reassessment or during a significant change, the Case Manager will ensure that the current ICD-9 relates to the individual's need for moderate needs services and will use the code translator to obtain the ICD-10 code.

The following sites may be used to look up codes:

- **ICD-9 Look up:** <http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx>
- **ICD-10 code look up:** <http://www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx>

The following site may be used to **translate** codes from ICD-9 to ICD-10:

(This resource is a non-qualified source and providers need to be conscious that it should only be used subjectively) <https://www.aapc.com/icd-10/codes/>

- B. If the Case Manager is unsure what diagnosis and ICD-9 code relates to the individual's need for moderate needs services, then the Case Manager shall contact the participant's primary care physician to obtain an ICD-9 and ICD-10 code that relates to

their need for services. If the physician has an ICD-9 code, but no ICD-10 code, then the Case Manager can use the ICD-10 code translator.

- C. The Case Manager shall include the ICD-9 and ICD-10 code on the applicable service authorization request form until the official change to ICD-10 on 10/1/15. After 10/1/15 only the ICD-10 code is needed.
- D. The DAIL Independent Living Services Consultant will enter the ICD-9 and ICD-10 code into the SAMS database in the care plan when doing utilization review and processing the service authorization request.

3. Changing to another CFC Option

1. The Case Manager shall obtain an ICD-10 code that applies to the individual's need for the service option the individual is transitioning to (i.e. Attendant Services or Long Term Care).
2. If the ICD-10 code is not available, obtain the ICD-9 code that relates to their need for long term services and supports or attendant services and use the code translator to obtain the ICD-10 code.

The following sites may be used to look up codes:

- **ICD-9 Look up:** <http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx>
- **ICD-10 code look up:** <http://www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx>

*The following site may be used to **translate** codes from ICD-9 to ICD-10:*

(This resource is a non-qualified source and providers need to be conscious that it should only be used subjectively) <https://www.aapc.com/icd-10/codes/>

3. The Case Manager shall include the ICD-9 and ICD-10 code on the applicable service authorization request until the official change to ICD-10 on 10/1/15. After 10/1/15 only an ICD-10 code is needed.
4. The DAIL LTCCC will enter the ICD-9 and ICD-10 code into the SAMS database in the care plan when doing utilization review and processing the service plan authorization for the new option if Long Term Services and Supports.
5. The DAIL Independent Living Services consultant will enter the ICD-9 and ICD-10 code into the SAMS database in the care plan when processing the service authorization for Attendant Services.

SECTION VI. Assessment Tools

An assessment is defined as a comprehensive, professional evaluation of an individual's circumstances, including but not limited to health, functional, social and financial needs.

A. Independent living Assessment (ILA)

The intake section of the ILA is utilized for individuals applying for and receiving Moderate Needs services. The Case Manager, through which the individual is applying, is responsible for initiating and overseeing the completion of the ILA intake. The ILA shall be shared with other Moderate Needs providers in order to be efficient and reduce duplication of effort.

NOTE: A "Permission For Release of Information" must be completed and accompany the ILA.