NEW MEXICO HEALTH CARE AUTHORITY
DEVELOPMENTAL DISABILITIES SUPPORTS
DIVISION MEDICALLY FRAGILE WAIVER (MFW)
SERVICE STANDARDS

HEALTH CARE
AUTHORITY

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NEW MEXICO HEALTH CARE AUTHORITY
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
MEDICALLY FRAGILE WAIVER (MFW) SERVICE STANDARDS

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Please note provider requirements may be located in more than one chapter. All providers are subject to Chapter 1 General Authority, and Chapter 2 General Provider Requirements, in addition to chapters related to specific services. All providers are responsible for ongoing requirements related to the provider agreement, memos from DDSD, and requirements pertaining to national disasters and public health emergencies.

CHAPTER 1
GENERAL AUTHORITY

The following Laws and standards, policies and procedures governing the provision of services under the Medically Fragile Medicaid Waiver include, but are not limited to:

The Centers for Medicare and Medicaid Services (CMS) Requirements for Home and Community-Based Services Waivers

CMS Rulings such as decisions of the Administrator, precedent final opinions, orders and statements of policy and interpretation

Health Insurance Portability and Accountability Act (HIPAA) of 1996, including the CMS Administrative Simplification Provisions

New Mexico Human Services Department (HSD) Medicaid Policy Manual, Medically Fragile Home and Community-Based Services Waiver Services ([8.314.3 New Mexico Administrative Code (NMAC)]; including Manual Revision Memorandum 10-29

Final Register vol.29 No. 54, February 27, 2018 Medically Fragile Home and Community-Based Services Waiver

Final Register vol.40 No 10, June 13, 2017 Billing for Services and Cost Sharing

HSD Medicaid Program Policy Manual

HSD Billing for Medicaid Services, 8.302.2 NMAC

HSD Medical Assistance Division Provider Participation Agreement (MAD 335)

Fair Labor Standards Act of 1938 (FLSA), as amended 29 USC §201 et seq.; 29 CFR Parts 510 to 794

Pharmacy Act (Chapter 61, Article 11 NMSA 1978)

New Mexico Nursing Practice Act, Chapter 61, Article 3, New Mexico Statute Authority (NMSA)

Certified Medication Aide Rules (16.12.5. NMAC)
The DDSD Home and Community-Based Waiver Provider Agreement

DOH/DDSD Client Complaint Procedures (7.26.4 NMAC)

Long Term Services – Waivers Medically Fragile Home and Community – Based Services Waiver Services (8.314.3 NMAC)

Medicaid Eligibility – Home and Community–Based Services (8.290.400. NMAC)
Medicaid General Provider Policies (8.302.1 NMAC)

CHAPTER 2
GENERAL PROVIDER REQUIREMENTS

These standards apply to all services provided through the Medicaid Home and Community-Based Services Waiver Program for participants with the Medically Fragile Waiver (MFW). These standards interpret and further enforce the New Mexico Human Services Department (HSD) Medicaid Policy Manual for MFW and the Centers for
Medicare and Medicaid Services (CMS) requirements for Home and Community-Based Services Waivers

I. PROVIDER REQUIREMENTS

A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD.

B. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to adhere to requirements as outline in the CMS HCBS Final Rule:
   1. Providers must ensure that settings are integrated in and support full access individuals to the greater community including:
      a. of Providing opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources; and
      b. Ensuring that individuals receive services in the community, to the same degree of access as individuals not receiving HCBS.
   2. Providers must ensure that the individual selects from among setting options including non-disability specific settings and options for a private unit in a residential setting. The provider setting must have person-centered service plans that document the options based on the individual's needs and preferences. For residential settings the person-centered plan must document resources available for room and board.
   3. Providers must ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
   4. Providers must ensure settings optimize individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.
   5. Providers must ensure settings facilitate individual choice regarding services and supports, and choice regarding who provides them.
   6. Additional HCBS Final Rule requirements relate to ensuring tenant protections, privacy, and autonomy for individuals receiving HCBS who do not reside in their own private (or family) home.

C. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities Supports Division (DDSD) Provider Enrollment Unit process:

   a. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures.
   b. All provider agencies that enter a contractual relationship with DOH to provide MFW services shall comply with all applicable regulations, policies and standards.
   c. Reference: http://dhi.health.state.nm.us/

D. All agencies must follow all applicable DDSD Policies and Procedures.

E. All agencies must have emergency plans for the agency for the protection of their employees and to support delivery or resumption of services.

F. All provider agencies that enter into a contractual relationship with DOH to provide MFW services which comply with all applicable standards herein set forth and are subject to sanctions for noncompliance with the provider agreement and all applicable rules and regulations.

G. Under no circumstances may a parent (or guardian), family member, or conservator receive payment for services delivered to their minor child under age eighteen (18). Also, under no circumstances may any individual receive payment for services delivered to their spouse.

II. PROVIDER AGENCY REPORT OF CHANGES IN OPERATIONS:

A. The provider agency must notify the DOH in writing of any changes in the disclosures required in this section within ten (10) calendar days. This notice must include information and documentation regarding such changes as the following: any change in the mailing address of the provider agency, and any change in executive director, administrator, and classification of any services provided.

B. Program Flexibility: If the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects conflicts with these standards, then prior written approval from the DOH is required. Such approval must provide for the terms and conditions under which the waiver of specific standard(s) is/are granted. The applicant or provider agency is required to submit a written request and attach substantiating evidence supporting the request to the Medically Fragile Waiver Program Manager at DOH/DDSD. DOH will only approve requests that remain consistent with the current federally approved MFW application.

III. CONTINUOUS QUALITY MANGEMENT SYSTEM

A. On an annual basis, MFW provider agencies are required to update and implement the Continuous Quality Improvement Plan. At the time of the DHI audit or upon request, the agency will submit a summary of each year's quality improvement activities and resolutions to the Provider Enrollment Unit.

B. The provider agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and that comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules and standards. The agency must review the policies and procedures every three years and update as needed.

C. Appropriate planning must take place with all Interdisciplinary Team (IDT) members, Medicaid state plan provider, other waiver providers and school services to facilitate a smooth transition from the MFW Program. The person's choices are given consideration whenever possible DOH policies must be adhered to during this process as per the provider's contract.

D. All provider agencies, in addition to requirements under each specific service standard, are required to develop, implement, and maintain, at the designated main agency office, documentation of policies and procedures, for the following:

    a. Coordination with other provider agency staff serving individuals receiving MFW services that delineates the specific roles of each agency staff.
    b. Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated.
    c. Agency protocols for disaster planning and emergency preparedness.

IV. PARTICIPANT TRANSITION TO A DIFFERENT PROVIDER AGENCY

When a waiver participant/person is transferred to a similar provider agency, the receiving agency is provided the minimum following records:

- Complete file for the past 12 months
- Current and prior year Individualized Service Plan (ISP); and
- Intake information from original admission to services

V. PROVIDER AGENCY CASE FILE FOR THE WAIVER PARTICIPANT

A. All provider agencies are required to maintain at the administrative office a confidential case file for each person that includes all the following elements:
    a. Emergency contact information for the following individuals/entities that includes addresses and telephone numbers for each:
        i. Consumer
        ii. Primary caregiver
        iii. Family/relatives, guardians or conservators
        iv. Significant friends, if appropriate
        v. Physician
        vi. Case manager

vii. Provider agencies
viii. Pharmacy, if appropriate

b. Individual's health plan, if appropriate
c. Individual's current ISP
d. Progress notes and other service delivery documentation
e. A medical history which may include demographic data; current and past medical diagnoses including the cause of the medically fragile conditions and developmental disability; medical and psychiatric diagnoses; allergies (food, environmental, medications); immunization.

B. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes.

VI. DOCUMENTATION

A. Provider agencies must maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed.

B. The documentation of the billable time spent with an individual are kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record must contain at least the following information:
   a. date and start and end time of each service encounter or other billable service interval.
   b. description of what occurred during the encounter or service interval; and
   c. signature and title of staff providing the service verifying that the service and time are correct.

C. All records pertaining to services provided to an individual must be maintained for at least six (6) years from the date of creation.

D. Verified electronic signatures may be used. An electronic signature must be HIPAA compliant, which means the attribute affixed to an electronic document must bind to a particular party. An electronic signature secures the user authentication, proof of claimed identity, at the time the signature is generated. It also creates the logical manifestation of signature, including the possibility for multiple parties to sign a document and have the order of application recognized and proven. In addition, it supplies additional information such as time stamp and signature purpose specific to that user and ensures the integrity of the signed document to enable transportability of data, independent verifiability, and continuity of signature capability. If an entity uses electronic signatures, the signature method must assure that the signature is attributable to a specific person and binding of the signature with each particular document.

CHAPTER 3
CASE MANAGEMENT

MFW nurse case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the medically fragile participant's/person's health needs through communication and available resources to promote safety, quality of care, and cost-effective outcomes (see Case Management Society of America [CMSA] definition of case management, http://www.cmsa.org.). The case manager will employ person-centered planning in this process. Person-centered planning is process that is directed and led by the recipient, with assistance as needed or desired from a representative or other person of the recipient's choosing. Person-centered planning is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the recipient. The person-centered process is an ongoing process that enables and assists the recipient to identify and access a personalized mix of paid and non-paid services and supports that assists him or her to achieve personally defined outcomes in the community.

MFW funded services are not replacements for the family system, informal caregiver support or other community services, but are supplements to the person's natural supports. The participant's/person's family and/or caregiver must continue all efforts in the care and support of the individual.

I. SCOPE OF SERVICES:

A. Case Management Services Include:
1. The case manager (CM) will identify and facilitate community resources for the participant/participant's representative and family, such as Family Infant Toddler (FIT) program, schools for the Individualized Educational Plan (IEP), Medicaid State plans (Centennial Care Managed Care Organizations [MCOs]), faith-based organizations and support organizations and family supports.
2. The CM will review and facilitate eligibility. At least annually and more often as needed, the CM will complete the Level of Care (LOC), Individual Service Plan (ISP) and appropriate budget(s), MAD 046, and coordinate EPSDT (Early Periodic Screening and Diagnostic Testing or children's Medicaid if client is under 21 years old. The CM will review the initial ISP and MAD 046 form at six (6) months from the date of approval.
3. The CM will have monthly contact with the participant/participant's representative to perform ongoing assessment of the MFW parameters and progress toward identified goals and objectives.
4. Any member of the Interdisciplinary Team (IDT) may call a meeting to consider changes to the LOC, ISP and/or MAD 046 form at any time.
5. The CM cannot be an authorized (designated) participant's representative.

B. Case Management Role in Pre-Assessments:

1. The date the applicant is logged into the DDSD Central Registry is recognized as the date of registration.
2. The contracted Case Management Agency will complete a telephonic pre-assessment for all applicants 30 years and younger, and others as requested by the MFW Program Manager.
3. The CM will utilize the MFW Eligibility Training Manual to complete the pre-assessment tool. Other documents will be utilized in the pre-assessment as needed.
4. The pre-assessment packet is forwarded to the MFW Program Manager for final determination of allocation.

C. Eligibility Determination and Level of Care (LOC)/Funding Following Allocation:
1. The Case Management Agency will work to complete the following within 90 days of receipt of the Primary Freedom of Choice (PFOC) from the Department of Health (DOH):
    - Initial eligibility determination paperwork
    - Individual Service Plan (ISP)/MAD 046 budget

   If unable to complete this process, the Case Management Agency will submit a Client Information Update (CIU) with the reason why the process cannot be completed.
2. The CM will meet with participant/participant's representative to review and explain the person's rights to privacy, dignity, respect and freedom from coercion and restraint, the MFW services and State Medicaid services. The CM will help the participant and family identify community resources. The participant and family will be given a Medically Fragile Family Handbook in paper or electronic form to assist in reinforcing this information.
3. The CM will assist the participant/participant's representative to set up the required appointment with the primary care provider (PCP) for a history and physical (H&P) that will be submitted as part of the LOC packet necessary for prior authorization. The initial H&P must be completed within 90 days of submission of the PFOC and must be completed within 12 months of the annual LOC process. A H&P is required annually as part of the LOC process.
4. The CM completes an assessment using the MFW parameters and other appropriate resources to write the Comprehensive Individualized Assessment-Family Centered Review (CIA/FCR). Refer to the MFW Eligibility Training Manual parameter instructions for details.
5. The CM and PCP complete the DOH 378, Long Term Care Assessment Abstract (LTCAA). The PCP must sign and date the LTCAA form, stating that the PCP has seen and evaluated the person.
6. The Level of Care (LOC) packets consist of the following:
    - LTCAA DOH 378 form
    - PCP's signed H&P
    - CIU for extensions
    - Other supporting medical documents as needed
7. The LOC packet is submitted to Medicaid Third Party Assessor (TPA) who will make a determination of the LOC. The LOC determines the funding amount available to the medically fragile person based on needs identified in the ISP during the LOC/ISP cycle.

8. When the Medicaid TPA approves the LTCAA form, the person is then deemed to meet the LOC for the MFW.
9. Concurrent to the Medicaid TPA review of the LOC, Income Support Division (ISD) reviews financial and non-financial criteria to complete a financial eligibility determination. ISD will review financial and non-financial (citizenship, residency, disability determination etc.) to complete a financial eligibility determination. The CM will assist the person as needed to arrange the eligibility appointment with ISD and complete the ISD eligibility review.
10. The approved LOC is forwarded by the TPA to the ISD office to be included in eligibility determination.
11. The participant is funded for waiver services based on LOC and age:

    For those persons less than 21 years of age:
    - $42, 000/year (regardless of assessed LOC.)
    - Persons less than 21 years of age are also eligible for EPSDT benefits. The EPSDT/MCO budget is utilized prior to accessing MFW funding.

    For those persons age 21 years and older:
    - Adult Level I -- $190,000
    - Adult Level II --$145,000
    - Adult Level III --$100,000

D. IDT Meeting and ISP Development and Budget Development (MAD 046 form):
1. The participant/guardian has the opportunity to be involved in all aspects of the ISP.
2. The purpose of IDT meetings is to develop the ISP, review effectiveness of the ISP and revise the ISP.
3. In preparation for an IDT meeting, the CM will offer the participant/participant's representative a list of waiver services as appropriate and will document selected services.
4. The IDT will be comprised of the participant/participant's representative, the PCP and all MFW providers and external providers. The MFW providers are expected to attend ISP meetings and all others are encouraged to attend.
5. The participant/guardian will choose a provider from the MFW secondary freedom of choice (SFOC) list. Each service listed on the MAD 046 form has a separate SFOC.
6. The participant/guardian is encouraged to contact provider agencies and interview the agency and potential providers. The participant/guardian selects who provides services based on available choice. The participant/guardian's signature on the SFOC indicates their choice of provider agency for a specific service.
7. For private duty nursing (PDN) services or respite services, the participant/participant's representative will meet with the potential Home Health Agency representative to discuss specific needs and skills that will be expected from the nurse and/or home health aide in an effort to match nurse and/or home health aide with the person and family.
8. When the medically fragile participant is under the age of 21 years, Early Periodic Screening, Diagnostic & Treatment (EPSDT) services will be provided by the State Medicaid Plan. The CM will facilitate the choice of provider agency based on the network. The participant/guardian makes the decision of who provides services based on available choices.

9. The following chart lists services for individuals 21 years and over, and services for those under 21 years on the MFW:

SERVICE CHOICES ON THE MAD 046 FORM

MFW Participant Less Than 21 Years of Age	**MFW Participant More Than 21 Years of Age**
Ongoing RN/Case Management (OCM)	Ongoing RN/Case Management (OCM)
Nutritional Counseling	Registered Nurse (RN), Licensed Practical Nurse (LPN), Home Health Aide (HHA)
Behavior Support Consultation	Therapy Services (Physical Therapy [PT], Occupational Therapy [OT], Speech Language Therapy)
PDN In-Home Respite	Nutritional Counseling
Respite	Behavior Support Consultation
Specialized Medical Equipment	PDN In-Home Respite
Specialized Therapy: Massage Therapy	Respite
Customized Community Group Supports	Specialized Medical Equipment
Individual Goods and Services	Registered Nurse (RN) 2 hours/ISP cycle to attend IDT
Environmental Modification Services	Specialized Therapy: Massage therapy
Vehicle Modification Services	Customized Community Group Supports
	Individual Goods and Services
	Environmental Modification Services
	Vehicle Modification

10. The CM will facilitate the IDT meeting. The CM will contact team members at least two (2) weeks prior to the scheduled IDT meeting with date, time, location and purpose of the IDT meeting. This notification may be by phone, written or electronic communication. Documentation of phone, written or electronic notification will be maintained in the person's CM file. The CM will also notify IDT members of cancellations and changes of IDT meeting.
11. The CM is responsible for the ISP signature sheet at the IDT meeting. The date, beginning and end time of the IDT meeting will be written on the signature sheet by the CM.
12. The ISP signature sheet will be attached to the person's ISP and distributed to the IDT with the ISP package. Team members who participate in the IDT by phone will be so indicated on the signature sheet in lieu of an actual signature.
13. The original copy of the ISP will be maintained at the CM agency file.
14. It is the responsibility of each IDT member to request additional documents from the CM.
15. The ISP will include the following:
    a. Basic information includes at a minimum: the medically fragile participant's name, address, phone number, date of birth, original identification number,

parent/guardian information, insurance information, race/ethnicity, primary language, primary diagnosis, ISP cycle and date of the IDT/ISP meeting to develop the plan.

b. A list of IDT members that includes both waiver and non-waiver providers with the following information:
    - Name of team member, including the CM name
    - Title
    - Business
    - Phone number
    - Fax number, if possible
    - Email address, if possible
    - Funding source
c. Present levels of functioning to include diagnosis, strengths and needs.
d. IDT members discuss and enumerate issues, strengths and needs with the medically fragile participant and family, and strategies that will be used to address them.
e. The ISP outcome is a statement of change that the participant/participant's representative wants to achieve. These include individualized goals and objectives and care activities/strategies for each service delivered. These are based on reasonable and measurable outcomes for the participant.
f. The participant/guardian has the opportunity to generate outcomes. Team members may assist the participant/participant's representative to identify goals/outcomes and support their choices.
g. Each ISP outcome statement is accompanied by a description of the methods, strategies and activities used to work towards the outcome, timelines, criteria for measuring progress and person(s) responsible. The participant/participant's representative with assistance from other medical team members (i.e., PCP and medical specialists) will prioritize the concerns involved in providing services.
h. An ISP statement for services and supports necessary to achieve the outcomes. The listing of services and supports shall include the frequency, duration, location, intensity (group or individual), method of delivery, and applicable payment information. Services and supports not funded by the MFW are included.

16. The provider agencies will submit to the CM all service plan(s) within 10 working days following the initial IDT meeting and when revised.
17. The CM will complete the ISP within 15 working days following the IDT meeting.
18. The CM will submit the completed Waiver Review Form (MAD 046 form), commonly known as the budget, based on the decisions of the IDT meeting.
19. Each service requested on the MAD 046 form must have a corresponding care activity/strategy in the ISP.
20. Provider agencies must be present at the IDT meeting or provide their input to the CM or designee before the IDT meeting. The CM or designee contacts the provider following the meeting to update on changes.
21. The signed SFOC form for each service provider must be maintained in the participant's CM file and sent to the provider agencies.
22. It is the joint responsibility of the CM, provider agency, and participant/participant's representative to monitor the MAD 046 form's maximum dollar amount allocated per LOC and ISP cycle to assure the budget does not exceed approved LOC.

23. The ISP packet is submitted to the Medicaid TPA for prior authorization. The ISP packet is comprised of the following:
    - ISP with all corresponding care activity/strategy;
    - MAD 046 form;
    - Signature sheet of IDT meeting; and
    - CIU, if necessary.
24. The applicant for the MFW may begin receiving services only after the Medicaid MF Waiver Category of Eligibility (COE) is approved and a budget is in place.
25. The LOC and ISP cycle dates do not change for the participant. If for any reason the LOC, ISP or MAD 046 form are unable to be completed prior to the end of the cycle, the CM will submit a CIU form to the MFW Program Manager or designee informing him or her of the delay in completion. The MFW Program Manager or designee will approve the extension of services.

II. CASE MANAGEMENT MONITORING

A. The CM monitors the effectiveness of services provided to the participant as identified through the ISP, written reports, contacts and coordination of services.

B. The CM is required to have monthly contact with the participant/family.
   1. Face-to-face visits with the participant must occur at least every other month.
   2. The CM will have a telephone conference with participant and/or family on the months that a face-to-face visit is not done.
   3. Monthly contacts must have supporting documentation by the CM that reflects active implementation of the ISP.
   4. At the face-to-face visits with the medically fragile participant, health, safety and welfare are monitored. Face-to-face visits and phone contacts must have supporting documentation by the CM indicating the participant or family were actively involved in the input of strategies and decisions involving the coordination of services.
   5. When the medically fragile participant is not able to participate and provide input regarding needs, effectiveness of the ISP, or health and safety needs, the CM will clearly and concisely document in the monthly CM's contact notes that the participant was unable to directly convey his/her needs and the reasons why. The participant's representative will provide information regarding the effectiveness of the ISP, health and safety measures implemented and additional needs of the person.
   6. The CM and the Home Health Agency are required monthly to discuss nursing and home health aide services. This will be documented in CM contact notes. The discussion and notes will reflect review budget of utilization, and review of known or newly identified person/family needs for support by Home Health Agency personnel.

C. The CM is required to comply with all policies and procedures regarding utilization review, including professional documentation standards.

D. The CM reviews the services identified in the ISP and perceived effectiveness of each service with the participant/family.

E. The CM will have ongoing contacts with waiver providers to review quality, effectiveness of the services and progress towards the ISP goals.

F. The CM will identify and resolve known situations that may be harmful or deemed potentially dangerous to the participant and/or others.

G. The CM, in conjunction with participant/family, will identify problems with providers. The specific problems will be reported to the provider agency and MCO care coordinator as appropriate for resolution. The CM may participate in the resolution of the problems.

H. The CM monitors the timeliness of services delivered.

I. The CM must report child and adult abuse, neglect and exploitation to the designated State agencies as per State and Federal regulations.

III. CASE MANAGEMENT AGENCY REQUIRMENTS

A. Case Management Agency:
1. A CM may not provide any other MFW services to individuals for whom the agency provides case management services.
2. The Case Management Agency may not employ as a CM any immediate family member or guardian of an individual served by the agency.
3. The MFW may consider other options for contracting case management services when there is a lack of qualified Case Management Agencies within any geographic area of the State. At its discretion, the DOH may waive this requirement when there is a lack of qualified case management agencies within a specific geographic area of the state. This may include, for example, contracting with licensed Medicaid Home Health Agencies that have qualified licensed RNs for case management coordination of services.
4. The Case Management Agency must maintain a current MFW provider status per DOH Provider Enrollment Unit policies, including compliance with the DDSD Accreditation Policy.
5. The Case Management Agency must provide readily accessible case management services to persons on a statewide basis or by DDSD Region (preferred). At its discretion, the DOH may contract for case management services for one or more counties within a region.

B. Case Manager Requirements:
1. A MFW CM must be a licensed RN in the State of New Mexico with current licensure as defined by the New Mexico Board of Nursing.
2. A MFW CM must have at least two (2) years of experience with the target population in pediatrics, critical care or public health fields. Specifically, one (1) year should have been in a home health program, community health program, hospital, publicly funded

institution, long term care program, or any other program addressing the needs of special populations.

3. The MFW CM will have knowledge and experience in:
    a. Human growth and social development.
    b. Various disease processes and assessment of the need for skilled intervention.
    c. Accessing existing community resources as well as development of resources and programs.
    d. Resources for support to individuals, families, and groups.
    e. Planning and management of services for individuals with medical fragility and developmental disabilities.
    f. Interpersonal communication skills.
    g. Interventions to act appropriately and quickly in a crisis.
    h. Working with the health, welfare, mental health, and agencies, such as Child Protective Services (CPS) and Adult Protective Services (APS) affecting the MFW population.
4. The MFW CM will be culturally sensitive to the needs and preferences of medically fragile persons and member of their households. Arrangement of written or spoken communication in another language may need to be considered.

C. Administrative Requirements:
    1. The Case Management Agency must comply with all applicable Federal, State, and waiver regulations, policies and procedures regarding case management code of ethics.
    2. The Case Management Agency will have an established method of information and data collection.
    3. The Case Management Agency will comply with all Federal, State, DOH and Human Services Department (HSD) regulations, policies and procedures, including but not limited to:
        a. Policies and procedures related to timely submission of medical eligibility determination.
        b. Policies and procedures related to service provision and appropriate supervision.
        c. Policies and procedures related to case management training.
        d. Policies and procedures related to reimbursement of case management services.
        e. Establish and maintain written grievance procedures.
    4. The Case Management Agency must purchase and maintain full professional liability insurance coverage.
    5. The Case Management Agency is responsible for assuring that all CMs have current New Mexico RN licensure.
    6. The Case Management Agency is responsible for providing ongoing and appropriate training to CMs.
    7. The Case Management Agency shall notify the DOH in writing of any changes in the mailing address of the Case Management Agency or any change in executive director, administrator or geographic location of services provided.

D. Documentation Requirements:
    1. Documentation must be completed in accordance with applicable Medically Fragile standards.

2. All documentation forms will contain at least: participant's name, date of birth, date of report, provider agency name, and CM's name and credentials.
3. All report pages and notes will include at least the participants' name, date and document title.
4. All documentation will be signed and dated by the CM. Verified electronic signatures may be used. CM name and credential typed on a document is not sufficient.
5. Each participant will have an individual clinical file (see general provider requirements).

IV. CARE COORDINATION

Under the MFW, participants receive ancillary/medical services through the Medicaid State Plan. Managed Care organizations (MCO) provide acute and ancillary medical and behavioral health services to the 1915 (c) HCBS recipients/MCO members. The MCO is responsible for ensuring a Comprehensive Care Plan is initiated upon enrollment and assigning a Care Coordinator for coordinating all services in the MCO Comprehensive Care Plan. Care coordination involves:

1. The Managed Care Organization (MCO) Care Coordinator (CC) will request a copy of the approved MFW LOC packet and ISP packet from the CM and utilize the LOC and ISP information to complete as much of the Client Needs Assessment (CNA) as possible prior to the MCO CC visit with the participant.
2. The CM and CC will work to coordinate MFW LOC assessments and/or CNA visits at the same time to reduce the burden on these families.
3. CC will not be required to conduct a monthly/quarterly face-to-face or telephonic contact for the MF members. The CM will conduct monthly visits and provide the MCO with copies of the visit notes. The MCO will review the visit notes monthly and update the CNA as needed.

V. REIMBURSEMENT

Each Case Management Agency is responsible for providing clinical documentation that identifies case management components of the provision of ISP services, including assessment information, care planning, intervention, communications care coordination, and evaluation. There must be justification in each medically fragile participant's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of contacts. All services must be reflected in the ISP that is coordinated with the participant/family and other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget.

A. Payment for case management services through this Medicaid Waiver is considered payment in full.

B. The case management services must abide by all Federal, State, HSD, and DOH policies and procedures regarding billable and non-billable items.

C. All billed services must not exceed the capped dollar amount for LOC.

D. Reimbursement for case management services will be based on the current rate allowed for the services.

E. The Case Management Agency must follow all current billing requirements by the HSD and DOH for CM services.

F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

G. The Case Management Agency has the responsibility to review and assure that the information on the MAD 046 form for their services is current. If an error is identified, the Case Management Agency will work with the Medicaid TPA to correct the MAD 046 form.

H. The MFW Program does not consider the following to be case management duties and will not authorize payment for:
   1. Performing specific errands for the participant/participant's representative or family that is not program specific;
   2. "Friendly visiting," meaning visits with participant outside of work scheduled;
   3. Financial brokerage services, handling of participant's finances or preparation of legal documents;
   4. Time spent on paperwork or travel that is administrative for the provider;
   5. Transportation of persons on the waiver;
   6. Pick up and/or delivery of commodities; and
   7. Other non-Medicaid reimbursable activities.

CHAPTER 4
BEHAVIOR SUPPORT CONSULTATION

A Behavior Support Consultant (BSC) is a licensed professional as specified by applicable State laws and standards. Behavior support consultation services assist the participant with a developmental disability, his or her parents and family members, as well as the direct support professionals (DSP). Behavior support consultation services for the medically fragile participant include: assessments, evaluations, treatments, interventions, follow-up services and assistance with challenging behaviors and coping skill development to promote or maintain the participant in the home environment. Services for the parents, family members and DSPs include training in dealing with challenging behaviors and assistance with coping skill development at home and in the community.

I. SCOPE OF SERVICES

A. Initiation of BSC Services:
Behavior support consultation services are initiated when the case manager (CM) identifies and recommends the service be provided to the participant/participant's representative. The case manager (CM) provides the participant/participant's representative with a secondary freedom of choice (SFOC) to select a provider agency. The CM is responsible for including recommended units of behavior support consultation services on the MAD 046 form. It is the responsibility of the participant/participant's representative, BSC, and CM, to assure units of therapy do not exceed the capped dollar amount determined for the participant's Level of Care (LOC) and Individual Service Plan (ISP) cycle. Strategies, support plans, goals and outcomes will be developed based on the identified strengths, concerns and priorities in the ISP.

B. Behavior Support Consultation Services Includes:
1. Providing assessments, development of treatment plans and interventions, training, monitoring of the participant, and planning modification as needed for therapeutic purposes within the professional scope of practice of the BSC.
2. Designing, modifying and monitoring the use of related activities for the participant/participant's representative that is supportive of the ISP.
3. Training families and DSPs in relevant settings as needed for successful implementation of therapeutic activities, strategies, and treatments.
4. Consulting with the Interdisciplinary Team (IDT) member(s), guardians, family, or support staff.
5. Consulting and collaborating with the participant/participant representative's, primary care provider (PCP) and/or other therapists and/or medical personnel for the purposes of evaluation of the participant or developing, modifying, or monitoring behavior support consultation services for the participant.
6. Observing the participant in all relevant settings to monitor the individual's status as it relates to therapeutic goals or implementation of behavior support consultation services and professional recommendations.

7. Services may be provided in a clinic, home, or community setting. BSC services, including training and monitoring may be delivered in person (face to face), via telehealth/telephonic (remote), or through a combination of methods, based on the task to be completed, and the BSC's assessment of the situation in collaboration with the individual and/or their guardian (if applicable). Unless there is a public health emergency, the BSC may not rely on providing only remote services during the ISP year.
8. BSC services may not replace services available through Medicaid or Medicare behavioral health services but may be provided concurrently.
9. Children and young adults who receive counseling or behavioral health services through their local school may also receive BSC services through the MF Waiver; the focus of their PBSP is limited to home and community, rather than the school setting. No more than five hours of service per year may occur in the school setting for school age children and young adults, only for attending IEP meetings and cross-over training.

C. Comprehensive Assessment Guidelines:

1. The BSC must perform an initial comprehensive assessment for each participant to give the appropriate behavior support recommendations, taking into consideration the overall array of services received by the participant. Initial and annual re-assessments must include face-to-face, in person evaluation unless they are conducted when under a Public Health Emergency or other State or Local Order

D. Attendance at the IDT Meeting:
   1. The BSC is responsible for attending and participating, either in person, via telehealth or by conference call in IDT meetings convened for service planning.
   2. If unable to attend the IDT meeting, the BSC is expected in advance of the meeting to submit recommended updates to the strategies, support plans, and goals and objectives. The BSC and CM will follow up after the IDT meeting to update the BSC on specific issues.
   3. The BSC is responsible for signing the IDT sign-in sheet.
   4. The BSC must document in the participant's clinical file the date, time, and any changes to strategies, support plans, and goals and objectives as a result of the IDT meeting.

E. Discharge Planning Documentation includes:
   1. Reason for discontinuing services such as but not limited to failure to participate; request from participant/participant's representative; goal completion; or failure to progress;
   2. Written discharge plan shall be provided to the participant/participant's representative and the CM by the BSC;
   3. Strategies developed with participant/participant's representative that can support the maintenance of behavioral support activities;
   4. Family and direct support professional training that is completed in accordance with the written discharge plan;

5. Discharge summary is to be maintained in the participant's clinical file and a copy is to be placed in the CM file and distributed to the participant/participant's representative.

II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS

A. All BSCs who are working independently, or as subcontractors, or as employees of a provider agency who offer behavior support consultation services shall meet all the requirements of the Medically Fragile Waiver (MFW) Service Standards.

B. The agency must maintain a current MFW provider status through the Department of Health (DOH) Provider Enrollment Unit. Contact Provider Enrollment Unit for details.

III. AGENCY/INDIVIDUAL ADMINISTRATIVE REQUIREMENTS

A. BSC Requirements:
   a. Master's degree from an accredited school for psychology, social work, counseling or guidance program and maintain current license as required by New Mexico State Law.
   b. Acceptable licensure includes:
      i. New Mexico Licensed Psychologist or Psychologist Associate.
      ii. New Mexico Licensed Independent Social Worker (LISW).
      iii. New Mexico Licensed Master Social Worker (LMSW).
      iv. New Mexico Licensed Clinical Counselor (LPCC).
      v. New Mexico Licensed Marriage and Family Therapist (LMFT)
      vi. New Mexico Licensed Health Counselor (LMHC)
      vii. Licensed New Mexico Licensed Clinical Social Worker (LCSW)
   c. Maintain a culturally sensitive attentiveness to the needs and preferences of participants and their families based upon culture and language. Communicating in a language other than English may be required.
   d. Licensed BSCs identified in Section (III) (A) of this document may provide billable behavior support consultation services.

B. Documentation Requirements:
   a. Documentation must be completed in accordance with applicable Medically Fragile Wavier, Human Services Department (HSD), and Federal guidelines.
   b. All documents must be identified by title of document, medically fragile participant's name, and date of documentation. Each entry will be signed with appropriate credential(s) and name of person making entry.
   c. Verified Electronic Signatures may be used. BSC name and credential(s) typed on a document is not acceptable.
   d. All documentation must be signed and dated by the BSC providing services.
   e. A copy of the annual evaluation and updated treatment plan must be provided to the CM within 10 working days following the IDT meeting. The treatment plan must

include intervention strategies, as well as frequency and duration of care. The goals and objectives must be measurable.

f. BSC progress/summary notes will include date of service, beginning/end time of service, location of service, description of service provided, participant/family/DSP response to service, and plan for future service.
g. The summary will include the number and types of treatment provided and will describe the progress toward BSC goals using the parameters identified in the initial and annual treatment plan and/or evaluation.
h. Any modifications that need to be included in the ISP must be coordinated with the CM.
i. Complications that delay, interrupt, or extend the duration of the program will be documented in the participant's medical record and in communications to the Physician/Healthcare provider as indicated.
j. Each participant must have a unique clinical file.

C. Review Physician/Healthcare provider orders at least annually and as appropriate, and recommend revisions on the basis of evaluative finding.

D. Copies of BSC contact notes and BSC documentation may be requested by the MFW Manager, Division of Health Improvement (DHI), or HSD for quality assurance purposes.

IV. REIMBURSEMENT

Each provider of a service is responsible for providing clinical documentation that identifies the DSP's role in all components of the provision of home care, including assessment information, care planning, intervention, communications, and care coordination and evaluation. There must be justification in each medically fragile participant's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant or representative and other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and must be covered by the MFW and authorized by the approved budget.

A. Payment for behavior support consultation services through this Medicaid waiver is considered payment in full.

B. The BSC must abide by all Federal, State, HSD, and DOH policies and procedures regarding billable and non-billable items.

C. All billed services must not exceed the capped dollar amount for the LOC.

D. Reimbursement for BSC services will be based on the current rate allowed for the services.

E. The agency must follow all current billing requirements by the HSD and DOH for BSC services.

F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

G. Service providers have the responsibility to review and assure that the information on the MAD 046 form for their services is current. If the provider identifies an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected.

H. The MFW Program does not consider the following to be professional BSC duties and will not authorize payment for:
   1. Performing specific errands for the participant, their representative or family that is not program specific;
   2. "Friendly visiting," meaning visits with the participant outside of work scheduled;
   3. Financial brokerage services, handling of medically fragile participant's finances or preparation of legal documents;
   4. Time spent on paperwork or travel that is administrative for the provider;
   5. Transportation of medically fragile participant or their representative;
   6. Pick up and/or delivery of commodities; and
   7. Other non-Medicaid reimbursable activities.

CHAPTER 5
NUTRITIONAL COUNSELING

Nutritional counseling is provided by a Licensed Registered Dietitian (LRD) or Licensed Nutritionist (LN) licensed by the New Mexico Nutrition and Dietetic Practice Board. Nutritional counseling is designed to meet unique nutritional needs presented by persons with medical fragility and developmental disabilities. This does not include oral-motor skill development such as that provided by a speech language pathologist. Participants who may require nutritional counseling include, but are not limited to, children and/or adults with specific illnesses such as failure to thrive, gastro esophageal reflux, dysmotility of the esophagus and stomach, etc., or who require specialized formulas, or who receive tube feedings, or parenteral nutrition. Nutritional counseling services for Medically Fragile Waiver (MFW) participants under the age of 21 years may be funded through the Medicaid Early Periodic Screening, Diagnostic & Treatment (EPSDT) program. Nutritional counseling services are indicated for the person's nutritional needs if one or more of the following conditions exist:

1. Weight Loss (greater or equal to 5% usual body weight)
2. Eating disorders
3. Malnutrition
4. Enteral/Parental feedings
5. Diabetes Mellitus
6. Ostomy Management
7. Renal Disease/Failure
8. Nutritional Support (deficit related to diet/nutritional requirements)
9. Difficulty Swallowing
10. Education/training family members regarding diet and administration/feeding methods

I. SCOPE OF SERVICES

A. Initiation of Nutritional Counseling Services:
When nutritional counseling is identified as a recommended service, the Case Manager (CM) will provide the participant/participant's representative with a Secondary Freedom of Choice (SFOC). The participant/participant's representative selects a nutritional counseling agency from the SFOC. The identified LRD/LN requests a nutritional counseling prescription from the treating Physician/Healthcare Provider for evaluation and ongoing treatment. A copy of the written referral will be maintained in the participant's file with the provider. This referral must be obtained before initiation of treatment. The CM is responsible for including recommended units of nutritional counseling services on the MAD 046 form. It is the responsibility of the participant/participant's representative, the LRD/LN, and the CM to assure units of nutritional counseling do not exceed the capped dollar amount determined for the participant's Level of Care (LOC) and Individual Service Plan (ISP) cycle. Strategies, support plans, goals, and outcomes will be developed based on the identified strengths, concerns and priorities in the ISP.

B. Nutritional Counseling Services Include:
   1. Providing assessments and evaluations; development of treatment plans and interventions; monitoring of the participant; and identifying treatment plans as needed for therapeutic purposes within the professional scope of practice of the LRD/LN;
   2. Designing, building or preparing, implementing, modifying and monitoring the use of specialized or adaptive equipment within the scope of practice of a LRD/LN;
   3. Designing, modifying and monitoring of nutritional plans and services for the participant that is supportive of ISP desired outcomes;
   4. Training families, direct support professionals (DSP) in relevant settings as needed for successful implementation of nutritional plans, strategies, treatments, use of equipment and technologies or other aspects of nutritional counseling services;
   5. Consulting with Interdisciplinary Team (IDT) member(s), guardians, family, Physician(s)/Healthcare Provider or support staff as needed;
   6. Consulting and collaborating with the participant's Physician(s)/Healthcare Provider, family and direct support professionals for the purposes of evaluation of the participant or developing, modifying or monitoring nutritional services for the medically fragile person;
   7. Observing the participant in all relevant settings to monitor the participant's status as it relates to therapeutic goals or implementation of nutritional counseling services and professional recommendations;
   8. Providing other skilled LRD/LN treatments, interventions or assistive technologies deemed appropriate by the provider and within the scope of practice of the LRD/LN as licensed by the New Mexico Nutrition and Dietetic Practice Board overseen by the American Dietetic Association (ADA).

C. The nutritional plan must be updated at least every six (6) months:
   1. Prepare evaluations and progress summaries as required.
   2. Submit copies of evaluations/progress summaries to the CM every six (6) months.

D. Inform the CM of required changes to the individual dietary regimen as necessary.

E. Attendance at the IDT Meeting:
   1. The LRD/LN is responsible for attending and participating in IDT meetings convened for service planning, either in person, via telehealth or by conference call.
   2. If unable to attend IDT meeting, the LRD/LN is expected to submit to the family or CM in advance of the meeting any recommended updates to the nutritional plan. The LRD/LN and CM will follow up after the IDT meeting to update the dietician.
   3. The LRD/LN is responsible for signing the IDT sign-in sheet.
   4. The LRD/LN must document in the participant's clinical file the date, time, and any of changes to nutritional plan.

F. Discharge Planning Guidelines Must Include:
   1. Reason for discontinuing services such as but not limited to: failure to participate; request from participant/participant's representative; goal completion; or failure to progress;
   2. Written discharge plan in place with person/person's representative;

3. Strategies are developed with participant/participant's representative who can support the maintenance of nutritional supports;
4. Family and DSP's training is to be completed in accordance with written discharge plan;
5. Discharge summary is to be maintained in the provider's participant's file and a copy placed in the CM file and distributed to the participant/participant's representative.

II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS

A. Nutritional Counseling Requirements:
   1. Nutritional counseling is provided by a LRD/LN licensed by the New Mexico Nutrition and Dietetic Practice Board.
   2. The LRD/LN will be culturally sensitive to the needs and preferences of participants and their families. Communicating in a language other than English may be required.

B. Agency/Individual Administrative Requirements:
   The provider agency will:
   1. Maintain current report data/documentation for each person and make it available upon request of the Department of Health (DOH)/Developmental Disabilities Supports Division (DDSD) or its designee.
   2. Develop, implement and document services as identified on the ISP as coordinated with the CM in a manner fulfilling participant and/or family specific needs.
   3. Provide copies of LRD/LN contact notes, assessment, and other documentation as requested by the MFW Program Manager, Division of Health Improvement (DHI) or Human Services Department (HSD) for quality assurance purposes.
   4. Comply with all applicable MFW General Standards.

III. REIMBURSEMENT

Each provider of a service is responsible for providing clinical documentation that identifies DSP's roles in all components of the provision of home care, including assessment information, care planning, intervention, communications, care coordination and evaluation. There must be justification in each participant's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the person/person's representative, and other caregivers as applicable. All services provided, claimed and billed for must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget.

A. Payment for nutritional counseling services through the MFW is considered payment in full.

B. Nutritional counselors must abide by all Federal, State, HSD and DOH policies and procedures regarding billable and non-billable items.

C. All billed services must not exceed the capped dollar amount for LOC.

D. Reimbursement for nutritional counseling services will be based on the current rate allowed for the services.

E. Nutritional counseling services are provided with the understanding that the Waiver is the payer of last resort.

F. The agency must follow all current billing requirements by the HSD and DOH for nutritional counseling services.

G. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

H. Providers of service have the responsibility to review and assure that the information on the MAD 046 form for their services is current. If the providers identify an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected.

I. The MFW Program does not consider the following to be professional nutritional counseling duties and will not authorize payment for:
   1. Performing errands for the participant/participant's representative or family that is not program specific;
   2. "Friendly visiting," meaning visiting with the person outside of LRD/LN work scheduled;
   3. Financial brokerage services, handling of participant finances or preparation of legal documents;
   4. Time spent on paperwork or travel that is administrative for the provider;
   5. Transportation of the medically fragile participant;
   6. Pick up and/or delivery of commodities; and
   7. Other non-Medicaid reimbursable activities.

CHAPTER 6
PHYSICAL THERAPY

Physical therapy is a skilled therapy service performed by a licensed Physical Therapist (PT). A licensed PT practitioner, as specified by applicable State Laws and Standards, provides the skilled therapy services. Physical therapy services must be necessary to improve and/or maintain gross or fine motor skills or to facilitate independent functioning and/or prevent progressive disabilities. Physical therapy services for Medically Fragile Waiver (MFW) participants/persons under the age of 21 are funded through the Medicaid Early Periodic Screening, Diagnostic & Treatment (EPSDT) program. Adults access therapy services under the state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period. Waiver services are provided when the limits of the state plan skilled therapy services are exhausted. This service standard is written for the MFW participant/person 21 years and older.

I. SCOPE OF SERVICE

A. Initiation of Physical Therapy Services:
When physical therapy is identified as a recommended service, the Case Manager (CM) will provide the participant/participant's representative with a Secondary Freedom of Choice (SFOC). The participant/participant's representative will select a therapy agency from the SFOC. The identified therapist will request a physical therapy referral/prescription from the Primary Care Provider (PCP) for evaluation and ongoing treatment. This must be obtained before initiation of treatment. A copy of the written referral will be maintained in the participant's file that is kept by the PT. The CM is responsible for including recommended units of therapy services on the MAD 046 form. It is the responsibility of the participant/participant's representative, PT and CM to assure units of therapy do not exceed the capped dollar amount determined for the person's Level of Care (LOC) and Individual Service Plan (ISP) cycle. The CM may approve two (2) hours for an initial evaluation on the annualized budget. Strategies, support plans, goals, and outcomes will be developed based on the identified strengths, concerns, priorities, and outcomes in the ISP.

B. Physical Therapy Services Include:
1. Providing assessments and evaluations, developing treatment plans and interventions, monitoring the participant, and modifying treatment plans for therapeutic purposes, within the professional scope of practice of the PT.
2. Designing, building or preparing, implementing, modifying, and monitoring the use of specialized or adaptive equipment, orthotic devices, and assistive technologies for the medically fragile participant.
3. Designing, modifying, or monitoring the use of related environmental modifications for the participant.
4. Designing, modifying, and monitoring the use of related activities for the person that is supportive of ISP desired outcomes.

5. Training families, direct support professionals (DSP), and appropriate individuals in relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments and use of equipment and technologies; or other aspects of physical therapy services.
6. Providing assessments for environmental accessibility adaptations and assistive technology needs within the professional scope of practice of physical therapy.
7. Consulting with Interdisciplinary Team (IDT) member(s), guardians, family, or support staff.
8. Consulting and collaborating with the participant's PCP and/or other therapists and/or medical personnel for the purposes of evaluating the participant, or developing, modifying, or monitoring physical therapy services for the medically fragile participant.
9. Observing the participant in all relevant settings to monitor the participant's status as it relates to therapeutic goals or implementation of physical therapy services and professional recommendations.
10. Providing other skilled physical therapy treatments, interventions, or assistive technologies deemed appropriate by the licensed PT.
11. Providing the therapy in a clinic, home, or community setting.

C. Comprehensive Assessment Guidelines:
The PT must perform an initial comprehensive assessment for each participant to determine appropriate physical therapy recommendations for consideration by the IDT in the context of the overall array of services received by the person. The comprehensive assessment must be done at least annually and when clinically indicated. The assessment will be used to develop and revise the strategies, support plans, goals, and outcomes for the participant and may include the following:
1. Review of pertinent medical history;
2. Musculoskeletal, Neuromuscular, Cardiovascular/Pulmonary and Integumentary systems;
3. Environment for needed adaptations and safety of environment;
4. Sensory status/perceptual processing;
5. Positions to support health and safety;
6. Sensory processing function;
7. Environmental access skills;
8. Instrumental activities of daily living (IADL) and activities of daily living (ADL) techniques to improve deficits, or effects of deficits.

D. Attendance at the IDT Meeting:
1. The PT is responsible for attending and participating in IDT meetings convened for service planning, either in person, via telehealth or by conference call.
2. The PT is responsible for signing the sign-in sheet at the IDT meeting.
3. If unable to attend the IDT meeting, the PT is expected to submit, in advance of the meeting, recommended updates to the strategies, support plans, goals and objectives for the team's consideration. The PT and CM will follow up after the IDT meeting to update the PT on specific issues.

4. The PT must document in the participants' clinical file the date, time, and any changes to the therapy strategies, support plans, goals, and objectives as a result of the IDT meeting.

E. Discharge Planning Document Includes:
   1. Reason for discontinuing services such as but not limited to: failure to participate; request from participant/participant's representative; goal completion; or failure to progress.
   2. Written discharge plan is provided to the participant/participant's representative and the CM.
   3. Strategies developed with participant/participant's representative that can support the maintenance of therapy activities.
   4. Family and DSP training completed in accordance with written discharge plan.
   5. Discharge summary maintained in the PT file and a copy placed in the CM file and distributed to the participant/participant's representative.

II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS

A. All PTs who are working independently, or as subcontractors, or employees of a therapy provider agency shall meet all the requirements of the MFW Service Standards.

B. The agency is required to maintain a current MFW provider status through the Department of Health (DOH) Provider Enrollment Unit policies. See Provider Enrollment Unit contract for details.

C. The PT with a current and active license issued by the New Mexico Physical Therapy Board under the New Mexico Regulation and Licensing Department (NMRLD) may provide billable physical therapy services in accordance with the American Physical Therapy Association (APTA) scope of practice.

D. A student physical therapist or a student physical therapist assistant may provide billable physical therapy services if a formal academic intern agreement is signed by the therapy Provider Agency and the university and 100% direct on-site supervision is provided for evaluation and treatment services by a licensed physical therapist or physical therapy assistant who is an approved DD Waiver therapist.

E. A Physical Therapy Assistant (PTA) with a current and active license issued by the New Mexico Physical Therapy Board under the NMRLD may provide billable physical therapy services in accordance with the APTA scope of practice. The PTA shall meet supervision provisions of New Mexico's Physical Therapy licensure standards stipulated by New Mexico Administrative Code.

F. Certified PTAs may perform physical therapy procedures and related tasks pursuant to a plan of care written by the supervising licensed PT. All related tasks and procedures performed by a PTA must be within a PTA scope of service following all APTA, Federal and State licensure requirements applicable to PTA services.

G. Licensed PTs and certified PTAs must be culturally sensitive to the needs and preferences of medically fragile persons and their households. Arrangement of written or spoken communication in another language may be required.

III. AGENCY/INDIVIDUAL ADMINISTRATIVE REQUIREMENTS

A. Training:
1. Whenever possible, family members and/or DSPs are to be trained in therapeutic strategies designed by the therapist and directed toward assisting the participant in achieving his/her goals and outcomes.
2. Training includes participant, family members/DSPs from all relevant settings.

B. Monitoring and Revising:
1. The PT is responsible for monitoring the progress of the participant toward the achievement of therapeutic goals and objectives, as well as progress toward desired outcomes in the ISP.
2. The PT is responsible for monitoring the performance of strategies outlined in therapy plans.
3. The PT monitors and revises assistive technology devices for proper function, appropriate settings, and needed updates.

C. Documentation:
1. Documentation must be completed in accordance with applicable MFW Standards and current guidelines established by the APTA.
2. All documentation forms is required to contain at least: participant's name, date of birth, date of the report, name of the therapy provider agency, and the therapist's name, credentials, and contact information. All documentation must follow NMLRD requirements for the PT and PTA.
3. Each entry must be signed with appropriate credential and name of person(s) making entry.
4. Verified electronic signatures may be used. PT or PTA name and credential typed on a document is not sufficient.
5. Each participant is required to have an individual clinical file.
6. A copy of the annual evaluation and updated treatment plan will be provided to the CM within ten (10) working days following the IDT meeting. The treatment plan must include intervention strategies, as well as frequency and duration of care. The goals and objectives must be measurable.
7. Therapy progress/summary notes must include date of service, beginning/end time of service, location of service, service provided, participant/family/DSP response to service, and plan for future service. The summary must include the number and types of treatment provided. Describe the progress toward therapy goals using the parameters identified in the initial and annual treatment plan and/or evaluation. Any modifications that need to be included in the ISP must be coordinated with the CM.

8. Complications that delay, interrupt, or extend the duration of the program must be documented in the participant's medical record and in communications to the Physician/Healthcare Provider as indicated.

D. Renew Physician/Healthcare Provider's orders at least annually and as appropriate and recommend revisions on the basis of evaluative findings.

E. Copies of PT contact notes and PT documentation may be requested by the MFW Program Manager, Division of Health Improvement (DHI), or Human Services Department (HSD) for quality assurance purposes.

IV. REIMBURSEMENT

Each provider of a service is responsible for providing clinical documentation that identifies the DSP's role in all components of the provision of home care, including assessment information, care planning, intervention, communications, and care coordination and evaluation. There must be justification in each person's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant's representative and other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget.

A. Payment for physical therapy services through this Medicaid waiver is considered payment in full.

B. Physical therapy services must abide by all Federal, State, and HSD and DOH policies and procedures regarding billable and non-billable items.

C. All billed services must not exceed the capped dollar amount for LOC.

D. Reimbursement for physical therapy services will be based on the current rate allowed for the services.

E. The agency must follow all current billing requirements by the HSD and the DOH for physical therapy services.

F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

G. Providers of service have the responsibility to review and assure that the information on the MAD 046 form for their services is current. If the provider identifies an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected.

H. The MFW program does not consider the following to be physical therapy duties and will not authorize payment for:
    a. Performing errands for the participant/participant's representative or family that is not program specific;
    b. "Friendly visiting," meaning visiting with the participant outside of physical therapy work scheduled;
    c. Financial brokerage services, handling of the medically fragile participant's finances or preparation of legal documents;
    d. Time spent on paperwork or travel that is administrative for the provider;
    e. Transportation of medically fragile persons;
    f. Pick up and/or delivery of commodities; and
    g. Other non-Medicaid reimbursable activities.

CHAPTER 7
OCCUPATIONAL THERAPY

Occupational therapy is a skilled therapy service performed by a licensed Occupational Therapist (OT). A licensed practitioner, as specified by applicable State Laws and Standards provides the skilled therapy services. Occupational therapy services must be necessary to improve and/or maintain fine motor skills and coordinate and/or facilitate the use of adaptive equipment. Occupational therapy services for Medically Fragile Waiver (MFW) participants under the age of 21 are funded through the Medicaid Early Periodic Screening, Diagnostic & Treatment (EPSDT) program. This service standard is written for MFW participants/person 21 years and older. Adults access therapy services under the state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period. Waiver services are provided when the limits of the state plan skilled therapy services are exhausted.

I. SCOPE OF SERVICES

A. Initiation of Occupational Therapy Services:
When occupational therapy is identified as a recommended service the case manager (CM) will provide the participant/participant's representative with a Secondary Freedom of Choice (SFOC). The participant/participant's representative will select a therapy agency from the SFOC. The identified therapist will request an occupational therapy referral/prescription from the Primary Care Provider (PCP) for evaluation and ongoing treatment. This must be obtained before initiation of treatment. A copy of the written referral will be maintained in the participant's file that is kept by the OT. The CM is responsible for including recommended units of therapy services on the MAD 046 form. It is the responsibility of the participant/participant's representative, OT, and CM to assure units of therapy do not exceed the capped dollar amount determined for the participant's Level of Care (LOC) and Individual Service Plan (ISP) cycle. The CM may approve two (2) hours for an initial evaluation on the annualized budget. Strategies, support plans, goals, and outcomes will be developed based on the identified strengths, concerns, priorities, and outcomes in the ISP.

B. Occupational Therapy Services Include:
1. Providing assessments and evaluations, developing treatment plans and interventions, monitoring the participant, and modifying treatment plans for therapeutic purposes, within the professional scope of practice of the OT.
2. Designing, building or preparing, implementing, modifying and monitoring the use of specialized or adaptive equipment, orthotic devices, and assistive technologies for the participant.
3. Designing, modifying, or monitoring the use of related environmental modifications for the medically fragile participant.
4. Designing, modifying, and monitoring the use of related activities for the person that is supportive of ISP desired outcomes.

5. Training families, direct Support Professionals (DSP) and relevant individuals in relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments and use of equipment and technologies or other aspects of occupational therapy services.
6. Providing assessments for environmental accessibility adaptations and assistive technology needs within the professional scope of practice of occupational therapy.
7. Consulting with Interdisciplinary Team (IDT) member(s), guardians, family, or support staff.
1. Consulting and collaborating with the participant's PCP and/or other therapists and/or medical personnel for the purposes of evaluation of the person, or developing, modifying or monitoring occupational therapy services for the medically fragile.
2. Observing the participant in all relevant settings to monitor their status as it relates to therapeutic goals or implementation of occupational therapy services and professional recommendations.
3. Providing other skilled occupational therapy treatments, interventions, or assistive technologies deemed appropriate by the licensed OT and within the scope of practice of the OT.
11. Providing therapy in a clinic, home, or community setting.

C. Comprehensive Assessment Guidelines:
The OT must perform an initial comprehensive assessment for each medically fragile participant to determine appropriate occupational therapy recommendations for consideration by the IDT in the context of the overall array of services received. The comprehensive assessment must be done at least annually and when clinically indicated. The assessment will be used to develop and revise the strategies, support plans, goals, and outcomes for the participant and may include the following:
1. Review of pertinent medical history;
2. Cognitive status;
3. Environment for needed adaptations and safety of environment;
4. Physical status, such as strength, joint mobility, fine-motor skills, coordination, and visual-motor skills;
5. Sensory status/perceptual processing;
6. Sensory processing function;
7. Environmental access skills; and
8. Instrumental activities of daily living (IADL) and activities of daily living (ADL) techniques to improve deficits, or effects of deficits

D. Attendance at the IDT Meeting:
1. The OT is responsible for attending and participating in IDT meetings convened for service planning, either in person, via telehealth or by conference call.
2. The OT is responsible for signing the sign-in sheet at the IDT meeting.
3. If unable to attend the IDT meeting, the OT is expected to submit, in advance of the meeting, recommended updates to the strategies, support plans, goals, and objectives

for the team's consideration. The OT and CM will follow up after the IDT meeting to update the OT on specific issues.

4. The OT must document in the participant's clinical file the date, time, and any changes to the therapy strategies, support plans, goals, and objectives as a result of the IDT meeting.

E. Discharge Planning Documentation Includes:

1. Reason for discontinuing services such as but not limited to: failure to participate; request from participant/participant's representative; goal completion; or failure to progress;
2. Written discharge plan is provided to the participant/participant's representative and the CM;
3. Strategies developed with participant/participant's representative that can support the maintenance of therapy activities;
4. Family and DSP training completed in accordance with written discharge plan;
5. Discharge summary maintained in the OT participant file and a copy to be placed in the CM file and distributed to participant/participant's representative.

II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS

A. All OTs who are working independently as subcontractors or employees of a therapy provider agency must meet all the requirements of the MFW Service Standards.

B. The agency must maintain a current MFW provider status through the Department of Health (DOH) Provider Enrollment Unit policies. See Provider Enrollment Unit contract for details.

C. An OT with a current and active license issued by the New Mexico Occupational Therapy Board under the New Mexico Regulation and Licensing Department (NMRLD) may provide billable occupational therapy services in accordance with the American Occupational Therapy Association (AOTA) scope of practice.

D. A Certified Occupational Therapy Assistant (COTA) with a current and active license issued by the NMRLD may provide billable occupational therapy services in accordance with the AOTA scope of practice. A COTA must be supervised by an OT licensed by the New Mexico Occupational Therapy Board and follow all supervision provisions of New Mexico's current Occupational Therapy Act.

E. A COTA may perform occupational therapy procedures and related tasks pursuant to a plan of care written by the supervising licensed OT. All related tasks and procedures performed by a COTA must be within a COTA scope of service following all AOTA, Federal and State licensure requirements applicable to COTA services.

F. OT and COTA must be culturally sensitive to the needs and preferences of medically fragile participants and households. Arrangement of written or spoken communication in another language must be considered.

III. AGENCY/INDIVIDUAL ADMINISTRATIVE REQUIREMENTS

A. Training:
1. Whenever appropriate, family members and/or DSPs are to be trained in therapeutic strategies designed by the therapist and directed toward assisting the participant to achieve his/her goals and outcomes.
2. Training includes participant, family members, and DSPs from all relevant settings.

B. Monitoring and Revising:
1. The OT is responsible for monitoring the progress of the participant toward the achievement of therapeutic goals and objectives, as well as progress toward desired outcomes in the ISP.
2. The OT is responsible for monitoring the performance of strategies outlined in therapy plans.
3. The OT will monitor and revise assistive technology devices for proper function, appropriate settings and needed updates.

C. Documentation Requirements:
1. Documentation must be completed in accordance with applicable MFW Standards and current guidelines established by the AOTA.
2. All documentation forms will contain at least the following: participant name, date of birth, date of the report, name of the therapy provider agency, and the therapist's name, credentials, and contact information. All documentation must follow NMLRD requirement for the OT and OTA.
3. All documents are identified by title of document, participant name and date of documentation. Each entry will be signed with appropriate credential and name of person making entry.
4. Verified electronic signatures may be used. OT or COTA name and credential merely typed on a document is not sufficient.
5. Each person will have an individual clinical file.
6. A copy of the annual evaluation and updated treatment plan will be provided to the CM within ten (10) working days following the IDT meeting. The treatment plan must include intervention strategies, as well as frequency and duration of care. The goals and objectives must be measurable.
7. Therapy progress/summary notes will include date of service, beginning/end time of service, location of service, service provided, person/family/DSP response to service; and plan for future service. The summary will include the number and types of treatment provided. Describe the progress toward therapy goals using the parameters identified in the initial and annual treatment plan and/or evaluation. Any modifications that need to be included in the ISP must be coordinated with the CM.

8. Complications that delay, interrupt, or extend the duration of the program will be documented in the participant's medical record and in communications to the Physician/Healthcare Provider as indicated.

D. Renew Physician/Healthcare Provider's orders at least annually and as appropriate and recommend revisions on the basis of evaluative findings.

E. Copies of OT and/or OTA contact notes and OT and/or documentation may be requested by the MFW Program Manager, Division of Health Improvement (DHI), or Human Services Department (HSD) for quality assurance purposes.

IV. REIMBURSEMENT

Each provider of a service is responsible for providing clinical documentation that identifies the DSP's role in all components of the provision of home care, including assessment information, care planning, intervention, communications, care coordination, and evaluation. There must be justification in each participant's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant representative, other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget.

A. Payment for occupational therapy services through this Medicaid waiver is considered payment in full.

B. Occupational therapy services must abide by all Federal, State, and HSD and DOH policies and procedures regarding billable and non-billable items.

C. All billed services must not exceed the capped dollar amount for LOC.

D. Reimbursement for occupational therapy services will be based on the current rate allowed for the services.

E. The agency must follow all current billing requirements by the HSD and the DOH for occupational therapy services.

F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

G. Providers of service have the responsibility to review and assure that the information on the MAD 046 form for their services is current. If the provider identifies an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected.

H. The MFW program does not consider the following to be occupational therapy duties and will not authorize payment for:
    4. Performing errands for the participant/participant representative or family that is not program specific;
    5. "Friendly visiting," meaning visiting with the participant outside of occupational therapy work scheduled;
    6. Financial brokerage services, handling of the participant's finances or preparation of legal documents;
    7. Time spent on paperwork or travel that is administrative for the provider.
    8. Transportation of the medically fragile participant;
    9. Pick up and/or delivery of commodities; and
    10. Other non-Medicaid reimbursable activities.

CHAPTER 8
SPEECH/LANGUAGE THERAPY

Speech language therapy is a skilled therapy service provided by a licensed Speech Language Pathologist (SLP). A licensed SLP practitioner, as specified by applicable State Laws and Standards, provides the skilled services. Speech language therapy services must be necessary to improve and/or maintain independent functioning with swallowing and communication. This may include the use of adaptive technologies. Speech language therapy services for Medically Fragile Waiver (MFW) participants under the age of 21 are funded through the Medicaid Early Periodic Screening, Diagnostic & Treatment (EPSDT) program. This service standard is written for the MFW participant/person 21 years and older. Adults access therapy services under the state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period. Waiver services are provided when the limits of the state plan skilled therapy services are exhausted.

I. SCOPE OF SERVICES

A. Initiation of Speech Language Therapy Services:
When speech language therapy is identified as a recommended service, the case manager (CM) will provide the participant/participant's representative with a Secondary Freedom of Choice (SFOC). The participant/participant's representative will select a therapy agency from the SFOC. The identified therapist will request a SLP referral/prescription from the Primary Care Provider (PCP) for evaluation and ongoing treatment. This must be obtained before initiation of treatment. A copy of the written referral will be maintained in the participant's file that is kept by the SLP. The CM is responsible for including recommended units of therapy services on the MAD 046 form. It is the responsibility of the participant/participant's representative, SLP, and CM to assure that units of therapy do not exceed the capped dollar amount determined for the person's Level of Care (LOC) and Individual Service Plan (ISP) cycle. The CM may approve two (2) hours for an initial evaluation on the annualized budget. Strategies, support plans, goals, and outcomes will be developed based on the identified strengths, concerns, priorities, and outcomes in the ISP.

B. Speech Language Therapy Services Include:
1. Providing assessments and evaluations, developing treatment plans and interventions, monitoring of the participant, and modifying treatment plans for therapeutic purposes within the professional scope of practice of the SLP.
2. Designing, fabricating, modifying, implementing and monitoring the use of specialized or adaptive equipment, augmentative/alternative communication (AAC) devices, and assistive technologies for the participant.
3. Designing, modifying or monitoring the use of related environmental modifications for the medically fragile participant.
4. Designing, modifying, and monitoring the use of related activities for the participant that is supportive of ISP desired outcomes.

5. Training families, medically fragile participant, direct support professionals (DSP), and all appropriate individuals in all relevant settings as needed for successful implementation of therapeutic activities, treatments, strategies, use of equipment and technologies or other aspects of speech language therapy services.
6. Providing assessments for assistive technology needs within the professional scope of practice of the SLP.
7. Consulting with Interdisciplinary Team (IDT) member(s), guardians, family, or support staff.
8. Consulting and collaborating with the participant's PCP and/or other therapists and/or medical personnel for the purposes of evaluating the medically fragile person, or developing, modifying, or monitoring speech language therapy services.
9. Observing the participant in all relevant settings to monitor the participant's status as it relates to therapeutic goals or implementation of speech language therapy services and professional recommendations.
10. Providing other skilled speech language therapy treatments, interventions, or assistive technologies deemed appropriate by the licensed SLP.
11. Providing therapy in a clinic, home, or community setting.

C. Comprehensive Assessment Includes:

The SLP must perform an initial comprehensive assessment for each participant to determine appropriate speech language therapy recommendations for consideration by the IDT in the context of the overall array of services received. The comprehensive assessment must be done at least annually and when clinically indicated. The assessment will be used to develop and revise the strategies, support plans, goals, and outcomes for the participant and may include the following:

1. Review pertinent medical history;
2. Speech language disorders;
3. Assessing for swallowing disorders (dysphasia);
4. Communicative functions including underlying processes (i.e., cognitive skills, memory, attention, perception, and auditory processing; includes ability to convey or receive a message effectively and independently, regardless of the mode);
5. Oral motor function;
6. Use of prosthetic/adaptive/assistive devices;
7. Resonance and nasal airflow;
8. Orofacial myofunctional patterns;
9. Instrumental activities of daily living (IADL) and activities of daily living (ADL) techniques to improve deficits or effects of deficits.

D. Attendance at the IDT Meeting:

1. The SLP is responsible for attending and participating in IDT meetings convened for service planning, either in person, via telehealth or by conference call.
2. The SLP is responsible for signing the IDT sign-in sheet.
3. If unable to attend the IDT meeting, the SLP is expected to submit, in advance of the meeting, recommended updates to the strategies, support plans, goals, and objectives for the team's consideration. The SLP and CM will follow up after the IDT meeting to update the SLP on specific issues.

4. The SLP must document in the participant's SLP clinical file the date, time, and any changes to strategies, support plans, goals, and objectives as a result of the IDT meeting.

E. Discharge Planning Includes:
1. Reason for discontinuing services identified such as but not limited to: failure to participate, request from person/person's representative, goal completion, failure to progress;
2. Written discharge plan is provided to the participant/participant's representative and CM;
3. Strategies developed with participant/participant's representative that can support the maintenance of therapy activities;
4. Family and direct support professional DSP training completed in accordance with written discharge plan;
5. Discharge summary maintained in the SLP client file and a copy placed in the CM file and distributed to participant/participant's representative.

II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS

A. All SLPs who are working independently as subcontractors or employees of a therapy provider agency are required to meet all the requirements of the MFW Service Standards.

B. The agency must maintain a current MFW provider status though the Department of Health (DOH) Provider Enrollment Unit. See Provider Enrollment Unit contract for details.

C. The SLP, licensed by the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Board under the New Mexico Regulation and Licensing Department, may provide billable speech language therapy services in accordance with the American Speech/Language-Hearing Association (ASHA)'s scope of practice.

D. Licensed SLPs will be culturally sensitive to the needs and preferences of participants and members of their households. Communicating in a language other than English may be required.

III. AGENCY/INDIVIDUAL ADMINISTRATIVE REQUIREMENTS

A. Training:
- Whenever possible, family members and/or DSPs are to be involved and trained in therapeutic activities and strategies designed by the SLP and directed toward assisting the person in achieving his/her goals and outcomes.
- Training includes the participant, family and DSPs from all relevant settings.

B. Monitoring and Revising:

C. The SLP is responsible for monitoring the progress of the participant toward the achievement of therapeutic goals and objectives; as well as progress toward desired outcomes in the ISP.
D. The SLP is responsible for monitoring the performance of activities and strategies outlined in strategies and support therapy plans.
E. The SLP will monitor and make modifications to AAC devices to support proper function in settings of use and update the device as needed.

C. Documentation Requirements:
   1. Documentation must to be completed in accordance with applicable MFW Standards and guidelines established by ASHA.
   2. All documents are identified by title of document, participant's name, and date of documentation. Each entry will be signed with appropriate credential and name of person making entry.
   3. All documentation will be signed and dated by the SLP providing services. Verified electronic signatures may be used. SLP name and credentials typed on a document is not sufficient.
   4. Each person will have an individual clinical file.
   5. A copy of the annual evaluation and updated treatment plan will be provided to the CM within ten (10) working days following the IDT meeting. The treatment plan must include intervention strategies, as well as frequency and duration of care. The goals and objectives must be measurable.
   6. Therapy progress/summary notes will include date of service, beginning/end time of service, location of service, service(s) provided, participant/family/DSP response to service(s), and plan for future service. The summary will include the number and types of treatment provided. Describe the progress toward therapy goals using the parameters identified in the initial and annual treatment plan and/or evaluation, and any modifications that need to be included in the ISP must be coordinated with the CM.
   7. Complications that delay, interrupt, or extend the duration of the program will be documented in the participant's medical record and in communications to the Physician/Healthcare provider as indicated.

D. Review Physician/Healthcare provider orders at least annually and as appropriate; and recommend revisions based on evaluation findings.

E. Copies of SLP contact notes and SLP documentation may be requested by the MFW Manager, the Division of Health Improvement (DHI), or the Human Services Department (HSD) for quality assurance purposes.

IV. REIMBURSEMENT

Each provider of a service is responsible for providing clinical documentation that identifies the DSP's role in all components of the provision of home care, including assessment information, care planning, intervention, communications, and care coordination and evaluation. There must be justification in each person's clinical record

supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant's representative and other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget.

A. Payment for SLP services through this Medicaid waiver is considered payment in full.

B. The SLP services must abide by all Federal, State, HSD and DOH policies and procedures regarding billable and non-billable items.

C. All billed services must not exceed the capped dollar amount for LOC.

D. Reimbursement for SLP services will be based on the current rate allowed for the services.

E. The agency must follow all current billing requirements of the HSD and the DOH for SLP services.

F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

G. Providers of service have the responsibility to review and assure that the information on the MAD 046 form for their services is current. If the provider identifies an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected.

H. The MFW Program does not consider the following to be professional SLP duties and will not authorize payment for:
   1. Performing errands for the participant/participant's representative or family that is not program specific;
   2. "Friendly visiting", meaning visiting with the participant outside of SLP work scheduled;
   3. Financial brokerage services, handling of the medically fragile participant's finances or preparation of legal documents;
   4. Time spent on paperwork or travel that is administrative for the provider.
   5. Transportation of medically fragile participant;
   6. Pick up and/or delivery of commodities; and
   7. Other non-Medicaid reimbursable activities.

CHAPTER 9
HOME HEALTH AIDE (HHA)

All waiver participants are eligible to receive in-home Home Health Aide (HHA) services utilizing capped units/hours determined by approved Level of Care (LOC) Abstract and when justified on the Individual Service Plan (ISP) by the case manager (CM). The HHA or Certified Nursing Assistant is a paraprofessional member of the health care team who works directly under the supervision of a registered nurse (RN). The HHA performs total care or assists participant in all activities of daily living. The HHA will be assigned to assist in a manner that will promote an improved quality of life and a safe environment. The HHA duties/assignments will be in accordance with the participant's ISP and the Home Health (HH) Agency plan of care for the participant. The plan of care is a separate form from the CMS-485 form. HHA services for persons on the Medically Fragile Waiver (MFW) under the age of 21 are covered as under the Medicaid Early Periodic Screening, Diagnostic & Treatment (EPSDT) program. This service standard is written for the MFW participant 21years and older.

I. SCOPE OF SERVICES

A. Initiation of HHA Services:
When HHA is identified as a recommended service, the CM will provide the participant/participant's representative with a Secondary Freedom of Choice form (SFOC). The participant/participant's representative will select a HH Agency from the SFOC. The identified HH Agency will request a HHA referral/prescription from the primary care provider (PCP). This must be obtained before initiation of treatment. A copy of the written referral/prescription will be maintained in the participant's file with the HH Agency. The CM is responsible for including recommended units of HHA on the MAD 046. It is the responsibility of the participant/participant's representative, HH Agency and CM to assure that units/hours of HHA services do not exceed the capped dollar amount determined for the medically fragile participant's LOC and ISP cycle. Strategies, support plans, goals and outcomes will be developed based on the identified strengths, concerns, priorities and outcomes in the ISP.

B. HHA Service Includes:
1. Assisting with ambulation, transfer, and range of motion exercises under supervision of a Licensed Physical Therapist (PT), Licensed Occupational Therapist (OT) or Licensed Nurse (RN or LPN).
2. Assisting with menu planning, meal/snack preparation and assisting person with eating when necessary.
3. Assisting with bowel and bladder elimination, personal hygiene/personal care, pericare, catheter care, ostomy care, enemas, insertion of suppository (non-prescription), prosthesis care, and vital signs as ordered by a Physician/Healthcare provider and under supervision of a licensed nurse (RN or LPN).
4. The HHA may provide, with the approval of provider agency, services such as picking up medications and prompting participant to take medications.

5. The HHA will observe the general condition of participant and will report changes to the supervisor and primary caregiver/family. The HHA will document participant's status, changes in status, services furnished, and response to services.
6. The HHA will follow infection control practices.
7. The HHA will follow emergency procedures within scope of practice and report event to supervisor.
8. The HHA will respect participant's privacy, property and cultural differences.
9. The HHA may ride in the vehicle with the participant for the purpose of oversight during transportation. The HHA will accompany the participant to monitor or support him or her during transportation. This means the HHA many not operate the vehicle for purpose of transporting the participant without agency approval.
10. The HHA will follow regulations for HHA in State Regulations 7 NMAC 7.2 and Federal Regulations 42 CFR 484.
11. The HHA will follow documentation requirement per Federal Regulations 42 CFR 484 or State Regulations 4 NMAC 28.2 and MFW regulations.

C. Home Health Aide will not:
   1. Administer medications or tube feedings,
   2. Adjust oxygen levels,
   3. Perform any intravenous procedures,
   4. Perform any sterile procedures,
   5. Perform housekeeping services for members of the medically fragile person's family.

II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS

A. The HH Agency must be a current MFW provider with the Provider Enrollment Unit (PEU)/Developmental Disabilities Supports Division (DDSD).

B. HHA Qualifications:
   1. HHA Certificate from an approved community-based program following the HHA training Federal regulations 42 CFR 484.36 or the State Regulation 7 NMAC 28.2., or;
   2. HHA training at the licensed HH Agency which follows the Federal HHA training regulation in 42 CFR 484.36 or the State Regulation 7 NMAC 28.2., or;
   3. A Certified Nurses' Assistant (CNA) who has successfully completed the employing HH Agency's written and practical competency standards and meets the qualifications for a HHA with the MFW. Documentation will be maintained in personnel file.
   4. A HHA who was not trained at the employing HH Agency will need to successfully complete the employing HH Agency's written and practical competency standards before providing direct care services. Documentation will be maintained in personnel file.
   5. The HHA will be supervised by the HH Agency RN supervisor or HH Agency RN designee at least once every 60 days in the participant's home.
   6. The HHA will be culturally sensitive to the needs and preferences of the participants and their families. Based upon the individual language needs or preferences, HHA may be requested to communicate in a language other than English.

C. All supervisory visits/contacts must be documented in the participant's HH Agency clinical file on a standardized form that reflects the following:
   1. Service received;
   2. Participant's status;
   3. Contact with family members;
   4. Review of HHA plan of care with appropriate modification annually and as needed.

D. Requirements for the HH Agency Serving Medically Fragile Waiver Population:
   1. The HH Agency nursing supervisors(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN and HHA.
   2. The HH Agency staff will be culturally sensitive to the needs and preferences of participants and households. Arrangement of written or spoken communication in another language must be considered.
   3. The HH Agency will document and report any noncompliance with the ISP to the case manager.
   4. All Physician orders that change the participant's service needs should be conveyed to the CM for coordination with service providers and modification to ISP/MAD 046 if necessary.
   5. The HH Agency will document in the participant's clinical file that the RN supervision of the HHA occurs at least once every sixty days. Supervisory forms must be developed and implemented specifically for this task.
   6. The HH Agency and CM must have documented monthly contact that reflects the discussion and review of services and ongoing coordination of care.
   7. The HH Agency supervising RN, direct care RN and LPN trains families, direct support professionals and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments, use of equipment and technologies or other areas of concern.
   8. It is expected the HH Agency will consult with, Interdisciplinary Team (IDT) members, guardians, family, and direct support professionals (DSP) as needed.

III. ADMINISTRATIVE REQUIREMENTS

The administrative requirements are directed at the HH Agency, Rural Health Clinic or Licensed or Certified Federally Qualified Health Center.

A. The HH Agency will maintain licensure as a HH Agency, Rural Health Clinic or Federally Qualified Health Center, or maintain certification as a Federally Qualified Health Center.

B. The HH Agency will assure that HHA services are delivered by an employee meeting the educational, experiential and training requirements as specified in the Federal 42 CFT 484.36 or State 7 NMAC 28.2.

C. Copies of CNA certificates must be requested by the employer and maintained in the personnel file of the HHA.

D. The HH Agency will implement HHA care activities/plan of care per the participant's ISP identified strengths, concerns, priorities and outcomes.

E. A HH Agency may consider hiring a participant's family member to provide HHA services if no other staff are available. The intent of the HHA service is to provide support to the family, and extended family should not circumvent the natural family support system.

F. A participant's spouse or parent, if the participant is a minor child, cannot be considered as a HHA.

G. The HHA is not a primary care giver, therefore when the HHA is on duty; there must be an approved primary caregiver available in person. The participant and/or representative and agency have the responsibility to assure there is a primary caretaker available in person. The primary caregiver or a responsible adult must be available on the property where the participant is currently located and within audible range of the participant and HHA.

H. All designated primary caretakers' names and phone numbers must be written in the participant's emergency backup plan and agreed upon by the agency and / representative. The designated approved back up primary caregiver will not be reimbursed by the MFW/DDSD.

I. An emergency backup plan for participant medical needs and staffing must be developed, written, and agreed upon by the HH Agency and participant/participant's representative. This emergency back up plan will be available in participant's home. This plan will be modified when medical conditions warrant and will be reviewed at least annually.

J. The HH Agency will provide the participant/representative with agency contact information to include an after-hours phone.

IV. REIMBURSEMENT

Each provider of a service is responsible for providing clinical documentation that identifies direct care professional (DCP) roles in all components of the provision of home care, including assessment information, care planning, intervention, communications, and care coordination and evaluation. There must be justification in each participant's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant's representative and other caregivers as applicable. All services provided, claimed and billed must have documented justification

supporting medical necessity and be covered by the MFW and authorized by the approved budget.

A. Payment for HHA services through the Medicaid Waiver is considered payment in full.

B. The HHA services must abide by all Federal, State, HSD and DOH policies and procedures regarding billable and non-billable items.

C. The billed services must not exceed capped dollar amount for LOC.

D. The HHA services are a Medicaid benefit for children birth to 21 years through the children's EPSDT program.

E. The Medicaid benefit is the payer of last resort. Payment for HHA services should not be requested until all other third party and community resources have been explored and/or exhausted.

F. Reimbursement for HHA services will be based on the current rate allowed for the services.

G. The HH Agency must follow all current billing requirements by the HSD and the DOH for HHA services.

H. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

I. Providers of service have the responsibility to review and assure that the information on the MAD 046 for their services is current. If the provider identifies an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected.

J. The MFW Program does not consider the following to be professional HHA duties and will not authorize payment for:
   1. Performing errands for the participant/participant's representative or family that is not program specific;
   2. "Friendly visiting", meaning visits with participant outside of work scheduled.
   3. Financial brokerage services, handling of participant finances or preparation of legal documents;
   4. Time spent on paperwork or travel that is administrative for the provider;
   5. Transportation of participants without agency approval;
   6. Pick up and/or delivery of commodities; and
   7. Other non-Medicaid reimbursable activities.

CHAPTER 10
PRIVATE DUTY NURSING

All waiver participants are eligible to receive in-home private duty nursing (PDN) services by a registered nurse (RN) or licensed practical nurse (LPN) per capped units/hours determined by approved Level of Care (LOC) Abstract, and when nursing is identified as a need on the Individual Service Plan (ISP). Under the direction of the participant's Physician(s)/Healthcare Practitioner and in conjunction with the Case Manager (CM), participant, and the primary caregiver, the private duty nurse will develop and implement a nursing care plan that is separate from the ISP. PDN services for Medically Fragile Waiver (MFW) participants under the age of 21 are funded through the Medicaid Early Periodic Screening, Diagnostic & Treatment (EPSDT) program. This service standard is intended for the MFW participant/person 21 years and older.

I. SCOPE OF SERVICE

A. Initiation of PDN Services:
When a PDN service is identified as a recommended service, the CM will provide the participant/participant's representative with a Secondary Freedom of Choice (SFOC) form from which the participant/participant's representative selects a Home Health (HH) Agency. Working with the HH Agency and participant/participant's representative, the CM will facilitate the selection of a RN or LPN employed by the chosen agency. The identified agency will obtain a referral/prescription from the Primary Care Provider (PCP) for PDN services. This referral/prescription will be in accordance with Federal and State regulations for licensed HH Agencies. This must be obtained before initiation of treatment. A copy of the written referral will be maintained in the participant's file at the HH Agency. The CM is responsible for including recommended units/hours of services on the MAD 046 form. It is the responsibility of the participant/participant's representative, HH Agency and CM to assure that units/hours of therapy do not exceed the capped dollar amount determined for the participant's LOC and ISP cycle. Strategies, support plans, goals, and outcomes will be developed based on the identified strengths, concerns, priorities, and outcomes in the ISP.

B. Private Duty Nursing Services Include:
1. The private duty nurse provides nursing services in accordance with the New Mexico Nursing Practice Act, Chapter 61, and Article 3 NMSA 1978.
2. The private duty nurse develops, implements, evaluates and coordinates the medically fragile participant's plan of care on a continuing basis. This plan of care may require coordination with multiple agencies. A copy of the plan of care must be maintained in the participant's home.
3. The private duty nurse provides the participant, caregiver, and family all training and education pertinent to the treatment plan and equipment used by the participant.

4. The private duty nurse must meet the documentation requirements of the MFW, Federal and State HH Agency licensing regulations and all policies and procedures of the HH Agency where the nurse is employed. All documentation must include dates and types of treatments performed, as well as person's response to treatment and progress towards all goals.
5. The private duty nurse must follow the National HH Agency regulations (42 CFR 484) and state HH Agency licensing regulation (7.28.2 NMAC) that apply to PDN services.
6. The private duty nurse implements the Physician/Healthcare Practitioner orders.
7. The standardized CMS-485 (Home Health Certification and Plan of Care) form will be reviewed by the RN supervisor or RN designee and renewed by the PCP at least every sixty (60) days.
8. The private duty nurse administers Physician/Healthcare Practitioner ordered medication as prescribed utilizing all Federal, State, and MFW regulations and following HH Agency policies and procedures. This includes all ordered medication routes including oral, infusion, therapy, subcutaneous, intramuscular, feeding tubes, sublingual, topical, and inhalation therapy.
9. Medication profiles must be maintained for each participant with the original kept at the HH Agency and a copy in the home. The medication profile will be reviewed by the licensed HH Agency RN supervisor or RN designee at least every sixty (60) days.
10. The private duty nurse is responsible for checking and knowing the following regarding medications:
    a. Medication changes, discontinued medication, and new medication, and will communicate changes to all pertinent providers, primary care giver and family;
    b. Response to medication;
    c. Reason for medication;
    d. Adverse reactions;
    e. Significant side effects;
    f. Drug allergies; and
    g. Contraindications
11. The private duty nurse must follow the HH Agency's policy and procedure for management of medication errors.
12. The private duty nurse providing direct care to a medically fragile participant will be oriented to the unique needs of the participant by the family, HH Agency and other resources as needed, prior to the nurse providing independent services.
13. The private duty nurse develops and maintains skills to safely manage all devices and equipment needed in providing care for the participant.
14. The private duty nurse monitors all equipment for safe functioning and facilitates maintenance and repair as needed.
15. The private duty nurse will obtain pertinent medical history.
16. The private duty nurse will be responsible for the following:
    a. Obtaining pertinent medical history;
    b. Assisting in the development and implementation of bowel and bladder regimens and monitor such regimens and modify as needed. This includes removal of

fecal impactions and bowel and/or bladder training, urinary catheter and supra-public catheter care;

c. Assisting with the development, implementation, modification, and monitoring of nutritional needs via feeding tubes and orally per Physician/Healthcare Practitioner order and within the nursing scope of practice;

d. Providing ostomy care per Physician/Healthcare Practitioner order;

e. Monitoring respiratory status and treatments including the participant's response to therapy;

f. Providing rehabilitative nursing;

g. Collecting specimens and obtaining cultures per Physician/Healthcare Practitioner order;

h. Providing routine assessment, implementation, modification, and monitoring of skin condition and wounds;

i. Providing routine assessment, implementation, modification, and monitoring of Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL);

j. Monitoring vital signs per Physician/Healthcare Practitioner orders or per HH Agency policy.

17. The private duty nurse must consult and collaborate with the participant's PCP, specialists, other team members, and primary care giver/family, for the purpose of evaluation of the participant and/or developing, modifying, or monitoring services and treatment. This collaboration with team members will include, but will not be limited to, the following:
    a. Analyzing and interpreting the person's needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings;
    b. Identifying short and long-terms goals that are measurable and objective. The goals should include interventions to achieve and promote health that is related to the participant's needs.
18. The individualized service goals and a nursing care plan will be separate from the CMS-485. The nursing plan of care is based on the Physician/Healthcare Practitioner treatment plan and the medically fragile participant's and family's concerns and priorities as identified in the ISP. The identified goals and outcomes in the ISP will be specifically addressed in the nursing plan of care.
19. The private duty nurse must review Physician/Healthcare Practitioner orders for treatment. If changes in the treatment require revisions to the ISP, the agency nurse will contact the CM to request an Interdisciplinary Team (IDT) meeting.
20. The private duty nurse coordinates with the CM all services that may be provided in the home and community setting.
21. PDN services may be provided in the home or other community setting.
22. The private duty nurse may ride in the vehicle with the person for the purpose of oversight, support, or monitoring during transportation. The private duty nurse may not operate the vehicle for the purpose of transporting the participant.

C. Comprehensive Assessment includes:

The private duty nurse must perform an initial comprehensive assessment for each MFW participant. The comprehensive assessment is required to comply with all

Federal, State, HH Agency and MFW regulations. The comprehensive assessment must be done at least annually and when clinically indicated. The assessment will be used to develop and revise the strategies, nursing plan of care, goals, and outcomes for the participant. The comprehensive assessment must include at least the following:

1. Review of pertinent medical history;
2. Medical and physical status;
3. Cognitive status;
4. Home and community environments for safety;
5. Sensory status/perceptual processing;
6. Environmental access skills;
7. Instrumental activities of IADL and ADL techniques to improve deficits or effects of deficits;
8. Mental status;
9. Types of services and equipment required;
10. Activities permitted;
11. Nutritional status; and
12. Identification of nursing plans or goals for care

D. Attendance at the IDT Meeting:
   1. The HH Agency's RN supervisor is the HH Agency's representative at the IDT meeting. A RN alternative may represent the agency at the IDT meeting if the supervising nurse is unable to attend in person, via telehealth or by conference call.
   2. If unable to attend the IDT meeting, the nurse is expected to submit recommended updates to the strategies, nursing plan of care, goals, and objectives in advance of the meeting for the team's consideration. The nurse and CM will follow up after the IDT meeting to update the nurse on decisions and specific issues.
   3. The agency nurse or designee must document in the participant's HH Agency file the date, time, and coordination of any changes to strategies, nursing care plans, goals, and objectives as a result of the IDT meeting.
   4. Only one nurse representative per agency or discipline will be reimbursed for the time at the IDT meeting. The agency nurse representative must attend physically or telephonically in order to be reimbursed.
   5. The HH Agency nurse is responsible for signing the IDT sign-in sheet.
   6. Annually, and as needed, the agency RN may need to assist the CM with justification documentation supporting the modification to the approved budget (MAD 046 form).
   7. PDN services do not start until there is an approved MAD 046 form for nursing.

E. Discharge Planning includes:
   1. Reason for discontinuing services such as but not limited to: failure to participate; request from participant/participant's representative; or transition to another program;
   2. Written discharge plan provided to the person/person's representative and the CM;
   3. Strategies developed with participant/participant's representative to support person with ongoing medical needs;

4. Primary care giver and family training completed in accordance with written discharge plan.
5. PCP will be notified of discontinuation of PDN services.
6. The discharge summary will be maintained in the HH Agency clinical file, the PCP will be sent a copy, and a copy will be placed in the CM file as well as distributed to participant/participant's representative.

II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENT

A. PDN services must be furnished through a licensed HH Agency, licensed Rural Health Clinic, or certified Federally Qualified Health Center. All Federal/State requirements for each are applicable when providing services for the MFW participant.

B. All private duty nurses (RN or LPN) working as employees of the HH Agency must meet all the requirements of the MFW Service Standards, New Mexico Board of Nursing and HH Agency policies and procedures.

C. The HH Agency must maintain a current MFW provider status per Department of Health (DOH) Provider Enrollment Unit policies, including compliance with the Developmental Disabilities Supports Division (DDSD) Accreditation Policy.

D. The HH Agency must maintain the participant's file per Federal, State, and MFW regulations and policy.

E. Requirements for the HH Agency Serving the Medically Fragile Waiver Population:
   1. A RN or LPN in the state of New Mexico must maintain current licensure as required by the state of New Mexico Board of Nursing. The HH Agency will maintain verification of current licensure. Nursing experience in the area of developmental disabilities and/or medically fragile conditions is preferred.
   2. When the HH Agency deems the nursing applicant's experience does not meet MFW Standards, then the applicant can be considered for employment by the agency if he/she completes an approved internship or similar program. The program must be approved by the MFW Manager and Human Services Department (HSD) representative.
   3. The supervision of all HH Agency personnel is the responsibility of the HH Agency Administrator or Director.
   4. The HH Agency Nursing Supervisors(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN, and Home Health Aide (HHA).
   5. The HH Agency staff will be culturally sensitive to the needs and preferences of participant, participant representative and households. Arrangement of written or spoken communication in another language must be considered.
   6. The HH Agency will document and report any noncompliance with the ISP to the CM.

7. All Physician/Healthcare Practitioner orders that change the person's LOC will be conveyed to the CM for coordination with service providers and modification to the ISP/budget if necessary.
8. The HH Agency must document in the participant's clinical file RN supervision to occur at least every sixty (60) days. Supervisory forms must be developed and implemented specifically for this task.
9. The HH Agency and CM must have documented monthly contact that reflects the discussion and review of services and ongoing coordination of care.
10. The HH Agency supervising RN, direct care RN, and LPN trains the participant, family, direct support professional (DSP) and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments, use of equipment and technologies, or other areas of concern.
11. It is expected that the HH Agency will consult with the participant, IDT members, guardians, family, and DSP as needed.

III. ADMINISTRATIVE REQUIREMENTS

A. Training:
Whenever appropriate, the participant/participant's representative, family members, HHA, primary caregivers, and all relevant individuals are to be trained in techniques and technology that assist the participant with health and safety along with achievement of the person's ISP goals and outcomes.

B. Documentation Requirements:
1. Documentation is required to be completed in accordance with applicable MFW Standards, Federal HH Agency (42 CFR 484) regulations, or State HH Agency licensing (7.28.2 NMAC).
2. All documentation forms must contain at least the participant's name, date of birth, date of the report, name of the provider agency, RN and/or LPN name, credentials, and contact information.
3. All report pages and notes will include at least the person's name, date and document title.
4. All documentation will be signed with credential(s) listed and dated by the nurse. Verified electronic signatures may be used per HH Agency policy and procedure. Name and credential(s) typed on a document is not sufficient.
5. Each participant will have an individual clinical file (see General Provider service standard requirements). The content of the agency file documentation is primarily designed to reflect the person's treatments, response to treatments, condition, and the care provided to effect a change in that condition.
6. The nurse will develop a nursing plan of care separate from the Physician/Healthcare Practitioner treatment plan which includes strategies for managing the nursing care of the participant.
7. Progress notes must include dates, number, and types of treatments performed, participant's response to treatment, and progress toward therapy goals using the parameters identified in the initial and annual treatment plan and/or evaluation.

8. Any modifications that need to be included in the ISP must be coordinated with the CM.
9. A discharge summary will be maintained in the person's file per Federal, State and HH Agency record retention regulation/policy.
10. Complications that delay, interrupt, or extend the duration of PDN services must be documented in the participant's medical record and communicated to the Physician/Healthcare Practitioner.

C. The private duty nurse, per HH Agency policy and procedure, will review orders and treatment plans and, if appropriate, recommend revisions on the basis of evaluative findings.

IV. REIMBURSEMENT

Each provider of a service is responsible for providing clinical documentation that identifies the DSP's role in all components of the provision of home care: including assessment information, care planning, intervention, communications, and care coordination and evaluation. There must be justification in each person's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. Services must be reflected in the ISP that is coordinated with the person/person's representative, other caregivers as applicable, and authorized by the approved budget. All services provided, claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW.

A. Payment for PDN services through this Medicaid waiver is considered payment in full.

B. PDN services must abide by all Federal, State, and HSD and DOH policies and procedures regarding billable and non-billable items.

C. Billed services must not exceed the capped dollar amount for LOC.

D. PDN services are a Medicaid benefit for children birth to 21years, through the children's EPSDT program.

E. The Medicaid benefit is the payer of last resort. Payment for PDN services should not be requested until all other third-party and community resources have been explored and/or exhausted.

F. PDN services are a MFW benefit for the 21 year and older enrolled participant. The MFW benefit is the payer of last resort. Payment for waiver services should not be requested or authorized until all other third-party and community resources have been explored and/or exhausted.

G. Reimbursement for PDN services will be based on the current rate allowed for the services.

H. The HH Agency must follow all current billing requirements by the HSD and the DOH for PDN services.

I. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

J. Service providers have the responsibility to review and assure that the information on the MAD 046 form for their services is current. If providers identify an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected.

K. The MFW Program does not consider the following to be professional PDN duties and will not authorize payment for:
   1. Performing errands for the participant/participant's representative or family that is not program specific.
   2. "Friendly visiting," meaning visiting with the medically fragile participant outside of PDN work scheduled.
   3. Financial brokerage services, handling of participant finances or preparation of legal documents.
   4. Time spent on paperwork or travel that is administrative for the provider.
   5. Transportation of the medically fragile participant.
   6. Pick up and/or delivery of commodities.
   7. Other non-Medicaid reimbursable activities.

CHAPTER 11
RESPITE

Respite care services allow the primary caregiver a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. By permitting the caregiver a specific and limited break from the daily routine of providing care, burnout is reduced and the primary caregiver receives a source of support and encouragement to continue home care services. Respite services are provided for a maximum of fourteen (14) days or three hundred thirty-six (336) hours per ISP cycle.
Respite may be provided in the follow locations: the Medically Fragile Waiver participant's home or private place of residence, the private residence of a respite care provider, an intensive medical living services provider, or a specialized foster care home. The participant/person and or the participant's representative gives final approval of where respite services are provided.

I. SPECIALIZED RESPITE HOME

A. Definition: A specialized respite home is an agency licensed in New Mexico as a specialized foster home by the Protective Service Division (PSD) of the Children, Youth and Families Department (CYFD) or an intensive medical services provider approved by Developmental Disabilities Services Division (DDSD).
   1. Specialized respite care will be provided in the specialized foster care home under a licensed child placement agency.
   2. Intensive medical living services (IMLS) providers must adhere to the DDSD requirements for participation and be in good standing.
   3. The participant/participant's representative is required to request this service from their assigned Medically Fragile Waiver (MFW) Case Manager (CM).
   4. The agency must ensure the health and safety of each person when providing respite care services.

B. Scope of Service:
   The specialized respite care provider must adhere to the specific regulations regarding their licensure as an agency and the provision of care that is covered, including:
   1. Providing medical and nonmedical care;
   2. Preparing and assisting in preparation of meals and eating, and administering enteral (tube) feeding;
   3. Providing tracheotomy and ostomy care as appropriate;
   4. Monitoring all medical needs, such as providing ventilator/certified trained nursing staff as appropriate;
   5. Administering medications as ordered by the physician(s)/Healthcare Practitioner;
   6. Providing catheter and supra-pubic catheter care;
   7. Providing blood checks as ordered;
   8. Providing personal care, such as bathing, showering, skin care, grooming, oral hygiene, bowel and bladder care; also assisting with and providing recreational activities for leisure and play;

9. Assisting with enhancing self-help skills;
10. Using appropriate interpersonal communication skills and language and developing a trusting relationship with the person and his/her family from different social, cultural and economic background;
11. Providing body positioning, ambulation, and transfer skills;
12. Arranging for transportation to and from medical and therapy appointments;
13. Assisting in arranging with health care needs and follow up as directed by the primary caregiver, physician/Healthcare Practitioner and CM;
14. An emergency back-up plan must be in place prior to the initiation of the respite service. The back-up plan will include but is not limited to:
    a. The respite agency must receive copies of guardianship papers, and/or Medical Power of Attorney;
    b. The respite agency must receive contact information on guardians and individual(s) with Medical Power of Attorney;
    c. The participant's family must participate and agree to the agency's guidelines for the provision of back-up services.
15. It is the participant's family/ representative's responsibility to schedule a time to meet with the proposed agency and agency's care provider prior to the provision of respite services. This meeting will determine if the proposed care provider is a good match for the participant/participant's representative and to share information from the agency and the family.
16. The participant/participant's representative must follow the agency's guidelines for the provision of respite.
17. The CM will communicate as needed with the respite provider and the person/person's representative. The CM will provide the most current copy of the participant's Individual Service Plan (ISP), approved MAD 046 form, and all pertinent medical records.
18. The Home Health Agency (HH Agency) will communicate as needed with the respite provider and the participant/participant's representative. The HH Agency will provide the most current copy of the CMS-485, physician/Healthcare Practitioner orders and nursing care plan(s).

C. Agency Provider Requirements:
1. The agency is responsible to ensure that the direct support professional (registered nurse [RN], licensed practical nurse [LPN], home health aide [HHA], and agency's employees) meet all applicable MFW, State, and Federal requirements.
2. Licensed nurses must follow the New Mexico Nursing Practice Act.
3. The agency direct support professionals are required to provide non-medical services as listed under the scope of service.
4. Advance notice is required to be given to the CM for coordination of respite services. This includes a timeline.
5. A log of respite hours must be established for each person for financial accountability and reporting.
6. The CM must complete and approve required paperwork for the agency's respite services prior to implementation.

7. All services provided during respite must be documented in accordance with the documentation standards by the MFW, State, Federal, and agency requirements.
8. Only short-term respite care services will be funded for up to fourteen (14) days per year.
9. Specific Requirements for IMLS providers
    a. No more than four people may be supported in a single residence at one time. Such residences may include a mixture of people receiving IMLS and Supported Living.
    b. Daily nursing visits are required according to the following:
        i. A daily, face to face nursing visit must be made by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) to deliver the required direct nursing care, monitor each person's status, and oversee DSP delivery of health-related care and interventions.
        ii. Face to face nursing visits may not be delegated to DSP or non-licensed staff.
        iii. Although a nurse may be present in the home for extended periods of time based on individual(s) needs, a nurse is not required to be present in the home during periods of time when direct nursing services are not needed.
    c. RN oversight and on-call nursing is required.

D. Administrative Requirements:
1. The agency must be a licensed specialized foster care home under a licensed child care placement agency through the CYFD/PSD.
2. The agency must maintain a current MFW provider status per New Mexico Department of Health (DOH) Provider Enrollment Unit policies, including compliance with the Developmental Disabilities Supports Division (DDSD) Accreditation Policy.
3. The agency must develop an emergency response plan(s) that identifies and fulfills the person's needs.
4. The agency must have a minimum of two (2) years of experience working with persons who are medically fragile and developmentally disabled.

II. IN-HOME RESPITE

A. Scope of Service:
1. In-home respite provider must be a licensed HH Agency, licensed or certified Federally Qualified Health Center, or a Licensed Rural Health Clinic and a Medically Fragile Waiver Provider.
2. RN and LPN are the only category who can provide twenty-four (24) continuous hours of approved in-home respite services. RNs and LPNs must meet and comply with all MFW Private Duty Nursing (PDN) Standards.
3. The HH Agency must request and receive an agreement between the CM, HH Agency and participant/participant's representative to deliver in-home respite services by a HHA. This must be identified in the ISP.
    a. The participant/participant's representative is required to submit a request in writing to the CM.

b. The participant/participant's representative, CM and HH Agency will meet to develop the HHA respite plan.
c. The HHA plan for providing respite services must include but not limited to:
   i. Which approved primary care givers will be available to the HHA;
   ii. Which approved primary care givers will be providing services which are outside the HHA scope of practice;
   iii. Specific hours respite services will be provided. The HHA will not provide 24 continuous hours of respite;
d. The services provided must be within the scope of the HHA skills as identified in the MFW HHA standards;
e. A HH Agency RN or LPN must be available for back-up emergency services.

4. A list of approved primary care givers will be maintained in the home in a central location. This list will be signed by the participant/participant's representative.
5. It may be necessary to coordinate in-home respite services with more than one agency to provide 24-hour coverage by RN and/or LPN.
6. In-home respite services include medical and non-medical care.
7. An emergency back-up plan must be in place prior to the initiation of the respite service.

B. Agency Provider Requirement

1. The agency is responsible to ensure that the direct support professionals (RN, LPN, and HHA) meet all applicable MFW, State and Federal requirements for PDN and HHA.
2. The agency will follow the MFW PDN and HHA Standards.
3. Respite services must be provided by qualified personnel as delineated in the agency's licensure requirements and follow the MFW Standards and the MFW Provider Agreement.
4. Advance notice to the CM is required. This includes a timeline from the person/person's representative.
5. A log of respite hours used must be established and maintained.
6. The CM must complete and approve required paperwork for the agency's respite services prior to implementation.
7. All services provided during respite must be documented following the documentation standards by the MFW, State, Federal and agency requirements.
8. The agency personnel must be culturally sensitive to the needs and preferences of person and members of their household. Arrangement of written or spoken communication in another language may need to be considered.

III. REIMBURSEMENT

Each provider agency of a service is responsible for developing clinical documentation that identifies the direct support professionals' role in all components of the provision of home care, including assessment information, care planning, intervention, communications, and care coordination and evaluation. There must be justification in each person's clinical record supporting medical necessity for the care and for the approved Level of Care, that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the

participant/participant's representative, other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget.

A. Payment for respite services through the MFW is considered payment in full.
B. The respite services must abide by all Federal, State and Human Services Department (HSD) and DOH policies and procedures regarding billable and non-billable items.
C. All billed services must not exceed the capped dollar amount for respite services.
D. Reimbursement for respite services will be based on the current rate allowed for the services.
E. The agency must follow all current billing requirements by the HSD and DOH for respite services.
F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.
G. Service providers have the responsibility to review and assure that the information on the MAD 046 form is current. If the provider identifies an error, he/she will contact the CM or a supervisor at the case management agency immediately to have the error corrected.
H. The MFW Program does not consider the following to be respite service duties and will not authorize payment for:
    1. Performing errands for the participant/participant's representative or family that is not program specific;
    2. "Friendly visiting," meaning visiting with the person outside of respite work scheduled;
    3. Financial brokerage services, handling of participant finances or preparation of legal documents;
    4. Time spent on paperwork or travel that is administrative for the provider;
    5. Transportation of the medically fragile participant;
    6. Pick up and/or delivery of commodities; and
    7. Other non-Medicaid reimbursable activities.

CHAPTER 12
SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Specialized Medical Equipment and Supplies reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the New Mexico Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit to the participant/person. The costs of maintenance and upkeep of equipment are included in the cost of equipment and supplies. All items shall meet applicable standards of manufacture, design, and installation. This service does not include nutritional or dietary supplements

I. SCOPE OF SERVICES

A. Specialized Medical Equipment and Supplies (SME) are for the participant and are available to all qualified persons receiving MFW services. SME are required to be delivered as specified in the participant's ISP. This equipment will augment the New Mexico Medicaid State Plan. This equipment is necessary for life support and enhances the participant's quality of life. SME is as follows:
   1. Devices, controls or appliances specified in the plan of care that enable medically fragile participants to increase their ability to perform activities of daily living;
   2. Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live;
   3. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
   4. Such other durable and nondurable medical equipment not available under the New Mexico Medicaid State Plan that is necessary to address the person's functional limitations.
   5. All items shall meet applicable standards of manufacture, design, and installation.

B. Items purchased, or services delivered shall meet at least one of the following criteria:
   1. The item or service would increase the participant's functioning related to the medically fragile condition or disability;
   2. The item or service would increase the participant's safety in the home or community environment;
   3. The item or service would decrease dependence on other Medicaid funded services; or
   4. No other public funds are available to cover the items(s)/service(s).

C. SME may be provided in any location specified in the ISP.

D. The scope of SME may include, but is not limited to, the following:
   1. Purchasing SME must be authorized and placed on the budget by the case manager (CM) and identified in the Individual Service Plan (ISP) with the appropriate rationale, scope, duration and expected outcome.
   2. SME will not exceed $1,200 per ISP cycle year.

3. The CM may determine if an evaluation of the participant's need is necessary for assistive technology, Augmentative and Alternative Communication systems, environmental controls, voice output communication aides, Low/Medium/High Tech Assistive Technology (AT) devices and other equipment related to the medically fragile condition and/or disability to assist with:
   a. Helping to select and obtain appropriate devices;
   b. Designing, fitting and customizing those devices;
   c. Purchasing, repairing or replacing the devices; and
   d. Training the participant and/or family to use the devices effectively will need to be included in the SME capped dollar amount for an ISP cycle year. This evaluation and training will be provided by the appropriate discipline, such as Occupational Therapy (OT), Physical Therapy (PT), and Speech and Language Pathology (SLP).
4. The ISP will identify who is responsible for monitoring the effectiveness of the service and documenting effectiveness of service at least once during the first calendar year after delivery of service.
5. For a computer to be considered SME, the medically fragile participant must be the sole user of the computer system. The participant must be able to independently use the computer system with or without standard assistive technology devices. The fund will not be used to obtain software for recreational or leisure purposes but will be allowed for assistive technology to increase access to the community. This does not include access to intranet or other access ports.

E. Restrictions:

Purchases of SME are subject to the following limitations:

1. SME may not be used when items are covered by the New Mexico Medicaid State Plan, Division of Vocational Rehabilitation (DVR), and Individuals with Disabilities Education Act (IDEA) or Medically Fragile Waiver (MFW).
2. The purchase must meet the participant's non-covered functional, medical or social needs and must promote the desired outcomes of the person's ISP.
3. The purchase of items or services must not be prohibited by federal, state or local statutes and standards.
4. Nutritional or dietary supplements are not covered.
5. Recreational or leisure devices, such as stereo equipment, MP3 players, Wii, iPod, etc., are not covered.
6. SME funds may not be used for maintenance or repair of equipment not purchased with SME funds.
7. The CM will determine if SME is appropriate for ongoing maintenance or repair of equipment purchased with SME funds.

I. AGENCY/PROVIDER REQUIREMENTS

A. All SME Provider Agency(s) or Fiscal Agent(s) must be an approved provider through the Provider Enrollment Unit of the Department of Health (DOH).

B. The SME Provider Agency will maintain a complete accounting of all finances used for each person served. Complete accounting shall include a primary financial file for each participant that contains the following information:
   1. Written documentation of the service or equipment purchased that includes description.
   2. Receipts for service or equipment purchased.
   3. Written documentation of rationale, scope, duration and expected outcome will be maintained by the case management agency.
   4. Date of delivery to individual will be recorded by the SME Provider Agency.

C. The SME Provider Agency/ Fiscal Agent is required to provide quarterly reports of expenditures year to date to the CM and MFW Manager.

II. REIMBURSEMENT

All SME and supplies provided, claimed and billed must have documentation and be covered by the MFW and authorized by the approved budget.

A. Purchase only equipment or services approved on the budget (MAD 046).

B. Purchase only equipment and services consistent with scope of services subject to limitations.

C. Payment for SME services through the Medicaid Waiver is considered payment in full.

D. The agency must abide by all federal, state, Human Services Department and DOH policies and procedures regarding billable and non-billable items.

F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

E. All billed SME services must not exceed $1,000.00 per ISP cycle.

F. When submitting for reimbursement, provider agencies delivering SME may include a service fee for up to ten percent (10%) of the cost of the goods or services purchased to cover administrative costs. Provider service fees must be included as part of the budgeted cap of $1,200 per ISP cycle year.

G. If the item(s) exceeds the $1,200.00 minus Agency Administrative Fee, the SME Provider Agency is responsible for collecting any additional money prior to purchase. The MFW will not be responsible for money more than $1,200.00 per person's annual ISP cycle.

H. SME funds may not be used to pay for previously purchased durable items.

I. SME funds may not rollover and be combined with SME funds from future or prior ISP cycles.

CHAPTER 13
MASSAGE THERAPY (MT)

Massage therapy is a specialized therapy service performed by a Licensed Massage Therapist (LMT). A licensed LMT practitioner, as specified by applicable State Laws and Standards, provides the skilled therapy services. Massage therapy is a health care service that treats soft body tissue for therapeutic purposes, primarily for comfort and relief of pain. Massage therapy does not include the diagnosis or treatment of illness or disease. This service standard is written for all eligible MFW participants/persons.

I. SCOPE OF SERVICE

A. Initiation of Massage Therapy Services:

When Massage therapy is identified as a desired service, the Case Manager (CM) will provide the participant/participant's representative with a Secondary Freedom of Choice (SFOC). The participant/participant's representative will select a therapy agency from the SFOC. If there is no massage therapist on the SFOC or another LMT is desired, the participant/person may request the CM to assist with obtaining payment through a DDSD fiscal agent provider. The CM is responsible for including the desired units of LMT services on the MAD 046 form. It is the responsibility of the participant/participant's representative, LMT and CM to assure units of therapy do not exceed the benefit amount of $2,000 or units/dollar amount specified per Individual Service Plan (ISP) cycle.

B. Licensed Massage Therapy Services:

1. the treatment of soft tissues for therapeutic purposes, primarily comfort and relief of pain; it is a health care service that includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. within the professional scope of practice of the LMT. 16.7.1 NMAC
2. Providing the therapy in a clinic, home, or community setting.

C. Comprehensive Assessment Guidelines:

The PT must perform an initial comprehensive assessment for each participant to determine appropriate physical therapy recommendations for consideration by the IDT in the context of the overall array of services received by the person. The comprehensive assessment must be done at least annually and when clinically indicated. The assessment will be used to develop and revise the strategies, support plans, goals, and outcomes for the participant and may include the following:

1. Review of pertinent medical history;
2. Musculoskeletal, Neuromuscular, Cardiovascular/Pulmonary, and Integumentary systems;
3. Environment for needed adaptations and safety of environment;
4. Sensory status/perceptual processing;
5. Positions to support health and safety;

6. Sensory processing function;
7. Environmental access skills;
8. Does not include the diagnosis or treatment of illness or disease or any service or procedure for which a license to practice medicine, nursing, chiropractic, physical therapy, occupational therapy, acupuncture or podiatry is required by law." 16.7.1 NMAC
9. Under no circumstances will experimental massage techniques or services be consider a covered massage therapy service. Suspected violations must be reported to DHI and to the New Mexico Massage Therapy Board.

D. Attendance at the IDT Meeting:

1. The LMT is responsible for attending and participating in IDT meetings convened for service planning, either in person or by conference call.
2. The LMT is responsible for signing the sign-in sheet at the IDT meeting.
3. If unable to attend the IDT meeting, the LMT is expected to submit, in advance of the meeting, recommended updates to the therapy plan and objectives for the team's consideration. The LMT and CM will follow up after the IDT meeting to update the LMT on specific issues.
4. The LMT must document in the participants' file the date, time, and any changes to the therapy strategies, support plans, goals, and objectives as a result of the IDT meeting.
5. Attendance at the IDT Meeting is not a billable service.

E. Discharge Planning Document Includes:

1. Reason for discontinuing services such as but not limited to: failure to participate; request from participant/participant's representative; goal completion; or failure to progress.
2. Written discharge plan is provided to the participant/participant's representative and the CM.
3. Strategies developed with participant/participant's representative that can support the maintenance of therapy activities.
4. Family and DSP training completed in accordance with written discharge plan.
5. Discharge summary maintained in the LMT file and a copy placed in the CM file and distributed to the participant/participant's representative.

II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS

A. All LMTs who are working independently, or as subcontractors, or employees of a therapy provider agency shall meet all the requirements of the MFW Service Standards.

B. The agency is required to maintain a current MFW provider status through the Department of Health (DOH) Provider Enrollment Unit policies (See Provider Enrollment Unit contract for details.) or have services budgeted and paid through the fiscal agent.

C. All LMT providers must have a current and active license issued by the New Mexico Massage Therapy Board under the New Mexico Regulation and Licensing Department (NMRLD) may provide billable massage therapy services in accordance with the New Mexico scope of practice and as stipulated by the New Mexico Administrative Code.

D. Licensed MTs must be culturally sensitive to the needs and preferences of medically fragile persons and their households. Arrangement of written or spoken communication in another language may be required.

III. AGENCY/INDIVIDUAL ADMINISTRATIVE REQUIREMENTS

A. Documentation:

Documentation must be completed in accordance with applicable MFW Standards and current guidelines established by the AMTA.

1. All documentation forms is required to contain at least: participant's name, date of birth, date of the report, name of the therapy provider agency, and the therapist's name, credentials, and contact information.
2. Each entry must be signed with appropriate credential and name of person(s) making entry.
3. Verified electronic signatures may be used. LMT name and credential typed on a document is not sufficient.
4. Each participant is required to have an individual file.
5. Documentation must include date of service, beginning/end time of service, location of service, service provided, participant response to service. The summary must include the number and types of treatment provided. Any modifications that need to be included in the ISP must be coordinated with the CM.
6. Complications that delay, or interrupt, the duration of the program must be documented in the participant's record and in communications to the CM or Fiscal Agent as indicated.

B. Copies of LMT contact notes and documentation may be requested by the MFW Program Manager, Division of Health Improvement (DHI), or Human Services Department (HSD) for quality assurance purposes.

IV. REIMBURSEMENT

Each provider of a service is responsible for providing documentation that identifies the components of the provision of care, including as appropriate: assessment information, care planning, intervention, communications, and evaluation. There must be justification in each person's record supporting therapy provided that includes date of service, place of service, time in and out. All services must be coordinated with the participant/participant's representative and other caregivers as applicable. All services provided, claimed, and

billed must have documented justification supporting the services provided as covered by the MFW and authorized by the approved budget.

A. Payment for massage therapy services through this Medicaid waiver is considered payment in full.

B. Massage therapy services must abide by all Federal, State, and HSD and DOH policies and procedures regarding billable and non-billable items.

C. All billed services must not exceed the capped dollar amount for LOC.

D. Reimbursement for massage therapy services will be based on the current rate allowed for the services.

E. The agency must follow all current billing requirements by the HSD and the DOH for physical therapy services.

F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

G. Providers of service have the responsibility to review and assure that the information on the MAD 046 form for their services is current. If the provider identifies an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected.

H. The MFW program does not consider the following to be massage therapy duties and will not authorize payment for:
   1. Performing errands for the participant/participant's representative or family that is not program specific;
   2. "Friendly visiting," meaning visiting with the participant outside of physical therapy work scheduled;
   3. Financial brokerage services, handling of the medically fragile participant's finances or preparation of legal documents;
   4. Time spent on paperwork or travel that is administrative for the provider;
   5. Transportation of medically fragile persons;
   6. Pick up and/or delivery of commodities; and
   7. Other non-Medicaid reimbursable activities.

CHAPTER 14
CUSTOMIZED COMMUNITY GROUP SUPPORTS

Customized Community Group Supports can include participation in congregate day programs and community centers that offer functional meaningful activities that assist with acquisitions, retention or improvement in self-help, socialization, and adaptive skills for an eligible recipient. Customized Community Group Supports (CCGS) may include adult day habilitation programs, and other day support models.

Customized Community Group Supports are provided in integrated community settings such as day programs and community centers which can take place in non-institutional and non-residential settings.

These services are available at least four or more hours per day, one or more days pers wee. Service hours and days are specified in the eligible participant's Individual Service Plan

I. SCOPE OF SERVICES

A. Customized Community Group Supports include, but are not limited to the following:

1. Provide supports in integrated and congregate settings within the community which can include day programs and community centers that assist with the acquisition retention or improvement in self-help, socialization and adaptive skills.
2. Support and provide opportunities for participants to access and engage with community resources and activities with others in their community.
3. Creating individualized schedules that can be modified easily based on individual needs, preferences and circumstances, and that outline planned activities per day, week and month including date, time, location and cost of the activity.
4. Providing opportunities for active individual choice-making during the day, including daily schedules, activities, sill building and community participation.
5. Providing support to the person in becoming actively engaged in community sponsored activities specifically related to the person's (as compared to the group and or agency) interests and culture.

B. Service requirements and limitations, The CCGS Provider must adhere to the following guidelines:

1. The participant/participants representative is required to request this service from their assigned Medically Fragile Waiver Case Manager (CM);
2. The provide agency must ensure the health and safety of each person when providing CCGS.
3. CCGS are not segregated vocational or prevocational activities, e.g. center based or sheltered workshop. CCGS is only available to participants 18 and older when no longer enrolled in special education and related services (as defined in sections 602 (16) and (17) of the Education of the Handicapped Act) (20 U.S. C. 1401 (16) and (17) that are likewise available through a local education agency.
4. Assisting with enhancing self-help skills;

5. Using appropriate interpersonal communication skills and language and developing a trusting relationship with the person and his/her family from different social, cultural and economic background;
6. Providing body positioning, ambulation, and transfer skills;
7. The agency must ensure the health and safety of the person when providing CCGS.
8. It is the participant's family/ representative's responsibility to schedule a time to meet with the proposed agency prior to the provision of services. This meeting will determine if the proposed CCGS Provider is a good match for the participant/participant's representative and to share information from the agency and the family.
9. The participant/participant's representative must follow the agency's guidelines for the provision of CCGS.
10. The CM will communicate as needed with the CCGS Provider Agency.
11. The CCGS Provider Agency will communicate as needed with the Nurse Case Manager, the Home Health Provider and the participant/participant's representative.

II. AGENCY PROVIDER REQUIREMENTS:

A. The agency is responsible to ensure that the direct support professional (registered nurse [RN], licensed practical nurse [LPN], home health aide [HHA], and agency's employees) meet all applicable MFW, State, and Federal requirements.
B. Licensed nurses must follow the New Mexico Nursing Practice Act.
C. The agency direct support professionals are required to provide non-medical services as listed under the scope of service.
D. The CM must complete and approve required paperwork for the agency's CCGS services prior to initiation and continuation of services.
E. All services provided during respite must be documented in accordance with the documentation standards by the MFW, State, Federal, and agency requirements.
F. Only short-term respite care services will be funded for up to fourteen (14) days per year.

II. REIMBURSEMENT

Each provider agency of a service is responsible for developing clinical documentation that identifies the direct support professionals' role in all components of the provision of home care, including assessment information, care planning, intervention, communications, and care coordination and evaluation. There must be justification in each person's clinical record supporting medical necessity for the care and for the approved Level of Care, that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant's representative, other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget.

A. Payment for respite services through the MFW is considered payment in full.

B. The respite services must abide by all Federal, State and Human Services Department (HSD) and DOH policies and procedures regarding billable and nonbillable items.

C. All billed services must not exceed the capped dollar amount for respite services.

D. Reimbursement for respite services will be based on the current rate allowed for the services.

E. The agency must follow all current billing requirements by the HSD and DOH for respite services.

F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

G. Service providers have the responsibility to review and assure that the information on the MAD 046 form is current. If the provider identifies an error, he/she will contact the CM or a supervisor at the case management agency immediately to have the error corrected.

H. The MFW Program does not consider the following to be respite service duties and will not authorize payment for:
   1. Performing errands for the participant/participant's representative or family that is not program specific;
   2. "Friendly visiting," meaning visiting with the person outside of respite work scheduled;
   3. Financial brokerage services, handling of participant finances or preparation of legal documents;
   4. Time spent on paperwork or travel that is administrative for the provider;
   5. Transportation of the medically fragile participant; 6. Pick up and/or delivery of commodities; and 7. Other non-Medicaid reimbursable activities.

CHAPTER 15
INDIVIDUAL GOODS AND SERVICES

Individual Directed Goods and Services are services, equipment or supplies reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the New Mexico Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit to the participant/person. The costs of maintenance and upkeep of equipment are included in the cost of equipment and supplies. All items shall meet applicable standards of manufacture, design, and installation. This service does not include nutritional or dietary supplements,

I. SCOPE OF SERVICES

A. Individual Directed Goods and Services Supplies (IDGS) are for the participant and are available to all qualified persons receiving MFW services. IDGS are required to be delivered as specified in the participant's ISP. This equipment or service will augment the New Mexico Medicaid State Plan.

B. Individual directed goods and services must directly relate to the member's qualifying condition or disability. Individual directed goods and services must explicitly address a clinical, functional, medical, or habilitative need.
   1. Such other durable and nondurable medical equipment not available under the New Mexico Medicaid State Plan that is necessary to address the person's functional limitations.
   2. All items shall meet applicable standards of manufacture, design, and installation.

C. Items purchased, or services delivered must meet the following requirements:
   1. The item or service would increase the participant's functioning related to the medically fragile condition or disability.
   2. The item or service promotes the participant's safety and health in the home or community environment and reduces the risk for institutionalization.
   3. The item or service would accommodate the participant in managing his or her environment or facilitate activities of daily living.
   4. The item or service would decrease dependence on other Medicaid funded services; or facilitate activities of daily living.
   5. No other public funds are available to cover the items(s)/service(s).

D. IDGS may be provided in any location specified in the ISP.

E. The scope of IDGS may include, but is not limited to, the following:
   1. Purchasing IDGS must be authorized and placed on the budget by the case manager (CM) and identified in the Individual Service Plan (ISP) with the appropriate rationale, scope, duration and expected outcome.
   2. IDGS will not exceed $2,000 per ISP cycle year.

3. The CM may determine if an evaluation of the participant's need is necessary to evaluate the benefit or safety of the proposed goods or services other equipment related to the medically fragile condition and/or disability to assist with:
    a. Helping to select and obtain appropriate devices;
    b. Designing, fitting and customizing those devices;
    c. Purchasing, repairing or replacing the devices; and
    d. Training the participant and/or family to use the devices effectively will need to be included in the ISP and services obtained as necessary. This evaluation and training will be provided by the appropriate discipline, such as Occupational Therapy (OT), Physical Therapy (PT), and Speech and Language Pathology (SLP).
4. The ISP will identify who is responsible for monitoring the effectiveness of the service and documenting effectiveness of service at least once during the first calendar year after delivery of service.
5. The Case management file will include documentation of the rationale, scope, duration and expected outcome of the EDGS.
6. The fund will not be used to obtain software for recreational or leisure purposes but will be allowed for assistive technology to increase access to the community. This does not include access to the internet or other access ports.

F. Restrictions:
Purchases of IDGS are subject to the following limitations:

1. IDGS may not be used when items are covered by the New Mexico Medicaid State Plan, Division of Vocational Rehabilitation (DVR), and Individuals with Disabilities Education Act (IDEA) or Medically Fragile Waiver (MFW).
2. The purchase must meet the participant's non-covered functional, medical or social needs and must promote the desired outcomes of the person's ISP and have a direct link to a primary diagnosis of the person.
3. The purchase of items or services must not be prohibited by federal, state or local statutes and standards.
4. Nutritional or dietary supplements are not covered.
5. Recreational or leisure devices, such as stereo equipment, MP3 players, Wii, iPod, etc., are not covered.
6. IDGS funds may not be used for maintenance or repair of equipment not purchased with IDGS funds.
7. Experimental or prohibited treatments and goods are excluded.

II. AGENCY/PROVIDER REQUIREMENTS

A. All IDGS Provider Agency(s) must be an approved provider through the Provider Enrollment Unit of the Department of Health (DOH).

B. The IDGS Provider Agency will maintain a complete accounting of all finances used for each person served. Complete accounting shall include a primary financial file for each participant that contains the following information:

1. Written documentation of the service or equipment purchased that includes description.
2. Receipts for service or equipment purchased.
3. Date of delivery to individual will be recorded by the SME Provider Agency.

C. The IDGS Provider Agency is required to provide quarterly reports of expenditures year to date to the CM and MFW Manager.

III. REIMBURSEMENT

All SME and supplies provided, claimed and billed must have documentation and be covered by the MFW and authorized by the approved budget.

A. Purchase only equipment or services approved on the budget (MAD 046).

B. Purchase only equipment and services consistent with scope of services subject to limitations.

C. Payment for IDGS services through the Medicaid Waiver is considered payment in full.

D. The agency must abide by all federal, state, Human Services Department and DOH policies and procedures regarding billable and non-billable items.

E. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

F. All billed IDGS services must not exceed $2,000 per ISP cycle.

G. When submitting for reimbursement, provider agencies delivering IDGS may include a service fee of $120.00 purchased to cover administrative costs. Provider service fees must be included as part of the budgeted cap of $2,000 per ISP cycle year. If the provider agency has also provided purchasing for massage therapy the purchasing provider agency may include only one service fee of $120.00 for the purchasing of massage therapy and IDGS for one or both services per ISP year.

H. If the item(s) exceeds the $2,000 minus Agency Administrative Fee, the IDGS Provider Agency is responsible for collecting any additional money prior to purchase. The MFW will not be responsible for expenditures over $2,000 per person's annual ISP cycle.

I. IDGS funds may not be used to pay for previously purchased items or services.

J. IDGS funds may not rollover and be combined with IDGS funds from future or prior ISP cycles.

CHAPTER 16
ENVIRONMENTAL MODIFICATION SERVICES

Environmental Modification includes the purchase or installation of equipment and/or making physical adaptations to an individual's residence that are necessary to ensure the health, welfare and safety of the individual or enhance the individual's independence. All services must be provided in accordance with applicable federal, state, and local building codes. Environmental Modification is available to a person of any age and is coordinated with the person, guardian, Nurse Case Manager (CM), licensed contractors, and members of the IDT as necessary to ensure quality of service and meet the standard requirements.

I. SCOPE OF SERVICES

Environmental Modification addresses targeted medical, safety or functional concerns that incorporate the person's specific clinical and functional strengths and needs.

A. Examples of Environmental Modification include the following modifications of the person's physical environment, the accompanying purchases as well as the necessary installation services:
   1. widening of doorways/hallways;
   2. installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;
   3. lifts/elevators;
   4. modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing); turnaround space adaptations;
   5. specialized accessibility/safety adaptations/additions;
   6. trapeze and mobility tracks for home ceilings;
   7. automatic door openers/doorbells;
   8. voice activated, light-activated, motion-activated and electronic devices;
   9. fire safety adaptations; air filtering devices; heating/cooling adaptations;
   10. glass substitute for windows and doors;
   11. modified switches, outlets or environmental controls for home devices;
   12. and alarm and alert systems and/or signaling devices.

B. Improvements or repairs to the existing home, which do not provide direct medical, safety, or functional benefit to the person or which should be included as part of routine home maintenance cannot be approved. Such non-covered adaptations, modifications or improvements include:
   1. carpeting except for repairs to carpet needed due to permitted modification, e.g., repair to carpet in a door widening;
   2. roof repair;
   3. furnace replacement;
   4. remodeling bare rooms;

5. other general household repairs;
6. vehicle modifications; and
7. outdoor fences.

C. Duplicate environmental modifications cannot be approved. For example, if the person has a safe and usable ramp, a replacement ramp cannot be approved.

D. Environmental modifications cannot be used to fund new residential construction, even if the new dwelling is designed to accommodate the needs of individuals with I/DD.

E. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

F. Equipment that is covered under the State of New Mexico's Medicaid program cannot be

G. purchased under the MFW.

II. ENVIRONMENTAL MODIFICATION SERVICES PROVIDER AGENCY REQUIREMENTS

A. The Environmental Agency Services Provider (EMSP) must demonstrate the following:

1. The EMSP must have documentation verifying that the provider and any subcontractors utilized are bonded and Licensed Building Contractor(s) are authorized to complete the project by the State of New Mexico.
2. The EMSP must obtain all necessary permits as required by local and state laws.
3. The EMSP must demonstrate knowledge and work history showing the ability:
    a. to interpret the principles and practices of architecture, building codes and standards, building materials and construction methods, structural, mechanical, plumbing, and electrical systems;
    b. to interpret and prepare architectural working drawings and specifications, mediate contractual problems, and ensure compliance with all laws, rules and standards of the State of New Mexico, including the federal, state, and local building codes;
    c. to understand and implement contracting practices and procedures, construction cost estimating and knowledge of comparable costs to accomplish the adaptations;
    d. to incorporate architectural design, standards and technical data relating to building design and construction; and
    e. to interpret, implement and ensure that Federal ADA standards and applicable guidelines are followed in all environmental adaptations when applicable to the person's needs.

III. SERVICE REQUIREMENTS

A. Environmental Modification Services are available to all qualified participants receiving MFW services.
   1. The need for the Environmental Modification should be identified in the ISP and supported by a therapy home evaluation.
   2. The cost of the Environmental Modification plus the administrative fee cannot exceed the maximum cost of $5,000.00 every five ISP years.
   3. Environmental Modifications to the home owned by the person, owned by the guardian, owned by the family, or leased homes must be compliant with the MFW Waiver Standards and should meet the Americans with Disabilities Act (ADA) applicable guidelines when ADA guidelines will also meet the person's functional needs.

B. The CM must obtain a signed Verification of Benefit Availability form from the MFW Manager prior to approval of this service.

C. Pre- Service Requirements
   1. Nurse Case Manager
      a. Informs family that the total allowable expenditure for Environmental Modifications Services (EMS) is a maximum of $5,000.00 that is available to be added to the MFW budget once every five years. The $5,000 may be used at once or in portions over the 5-year period that begins on the date of Prior Authorization approval. If the planned modification exceeds $5,000.00, the family will be informed that they are responsible for paying all additional costs.
      b. Assures that the ISP reflects the need for EMS to an individual's residence that are necessary to ensure the health, welfare and safety of the person and enhance the individual's level of independence.
      c. Coordinates physician order for a Physical Therapy (PT) or Occupational Therapy (OT) home evaluation visit. A physician office visit may also be needed.
      d. Coordinates the PT or OT home evaluation visit through the EPSDT benefit for children or Medicare/Medicaid benefit for adults. The MFW therapy benefit for adults is the payer of last resort for this evaluation. If it is necessary to apply the MFW therapy benefit for this evaluation the CM provides the person with a Secondary Freedom of Choice (SFOC) form to select a MFW therapy provider.
      e. Provides the person/family with a Secondary Freedom of Choice (SFOC) form to select a MFW Environmental Modifications Services Provider (EMSP)
      f. Supports ongoing communication between the family, EMSP and the therapist as needed.
   2. Therapist
      a. The OT or PT completes the home visit, develops and provides recommendations and supporting documentation as needed for the Environmental Modifications to the family and CM, and EMSP.
   3. Any authorizations for additional consultation services related to the Modification will be obtained by the therapist as needed.
   4. EMSP
      a. Contacts family to set up home visit and informs the family, CM and therapist of the date and time.

b. Completes the home visit and creates Environmental Modification plan based on input from the person/family, CM and therapist.
c. Finalizes plans with person/family and therapist to meet the needs of the person in accordance with the MFW Environmental Modification Standards; federal, state and local building codes.
d. Submits proposed plan and all costs to the family and the CM within ten business days after first visit with homeowner/person/guardian.

5. Service may be provided when CM verifies that all preservice requirements are met, and person/family/homeowner accepts the plan and all required documents are present.
6. The EMSP completes all proposed work in compliance with the plans and to the satisfaction of the person/family.
7. After work is completed, the family signs and dates the original Environmental Modification plan, from the EMSP, verifying the satisfactory completion of work.
8. The EMSP provides copies of the final signed form to the family, CM and the MFW Manager within 5 business days of signature.
9. The EMSP retains the original forms for their files

Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

D. EMSP SERVICE REQUIREMENTS
1. Obtains a copy of the secondary freedom of choice.
2. The EMSP must coordinate planning for the environmental modification with the CM, the person/ guardian/ family, as applicable and the therapist who conducted the home assessment.
3. The EMSP must coordinate with the therapist and/or qualified person who provided the assessment to acknowledge, document and assure planned modifications will meet the person's clinical and functional needs:
    a. Coordination should occur at an in-person on-site evaluation.
    b. If in-person on-site coordination cannot occur or if this is not needed because the planned modification is very minor, coordination can occur via e-mail or phone with MFW Manager approval.
    c. Both the evaluator and the EMSP should document what was agreed upon regarding the Environmental Modification Plan during this meeting or through alternate communication.
4. The EMSP must develop an Environmental Modification assessment of the home and the scope of work needed to complete the modification.
5. The EMSP must provide an itemized price quote to the CM within ten business days after first visit with homeowner/person/guardian.
6. The EMSP must provide or secure licensed contractor(s) or vendor(s) to provide construction and/or remodeling services.
7. The EMSP must ensure that proper design criteria are addressed in planning and design of the adaptation.
8. The EMSP must interpret codes and clarify building procedures to the person, guardian, homeowner or other family members, CM, and Provider Agencies and DDSD prior to construction activities.

9. The EMSP must review plans submitted by sub-contractors, if applicable, for environmental modifications to ensure that the plans are architecturally sound, address functional needs outlined in the Environmental Modification Evaluation, and comply with state and local building codes and standards.
10. The EMSP must provide administrative and technical oversight of construction projects.
11. When requested, the EMSP must provide consultation to the person, guardian, homeowner or family, CM, and DDSD concerning environmental modification projects to the person's residence prior to or during construction activities.
12. The EMSP must ensure inspection of the final environmental modifications to ensure:
    a. compliance with all local, state, and federal codes and requirements
    b. the adaptation (s) meet the approved plan submitted for environmental adaptation.
13. The EMSP must meet reasonable timelines for completion of environmental modifications.
14. The EMSP must contact person/guardian/homeowner within one business week of being notified of the signed SFOC to schedule the initial site visit.
15. The EMSP must complete all modifications within six weeks of the approved budget. A waiver of this time-line must be sought from DDSD if extraordinary circumstances prevent the EMSP from meeting this requirement.
16. The EMSP must review accuracy of construction costs submitted by sub-contractors, if applicable.
17. The cost of the Environmental Modification plus the administrative fee cannot exceed the maximum cost of $5,000.00 every five ISP years. Administrative costs of the environmental Modification Service Provider (EMSP) will not exceed fifteen percent (15%) of the total cost of the environmental modification project managed by the Provider Agency.
18. The EMSP must provide a minimum of a one-year written warranty of the work completed, including both materials and labor, to person, guardian, family, homeowner and CM.
19. Withholding or denial of final payment may occur if the person in service or his/her guardian files a dispute to the MF Waiver Manager regarding the quality of work and the MFW Manager agrees with the complaint.

E. Cost of Materials:

1. Materials utilized in projects must be of Medium Grade and meet industry construction standards while considering the personal preferences of the homeowner.
2. MF Waiver funds may not be used for upgrades in materials that do not offer functional benefits to the person.
3. Purchase receipts for all materials must be kept in the EMSP file and must be furnished to the CM.

F. Documentation for Environmental Modification Services will be maintained by the MF CM. The EMS documentation will include: ISP section related to the need/goals for the EMS, the DDSD Benefit Verification form, the therapist's EMS Evaluation, secondary

freedom of choice form(s), EMS Plan, EMSP detailed cost report and documentation of work completion and acceptance/satisfaction by the individual/guardian/homeowner.

G. EMS documentation will be retained by the CM program and provided by MFW Manager upon request.

IV. USE OF FUNDS

A. Cost estimates, items and project plans are required to specifically identify the materials to be purchased and the labor costs associated with the expenditure of MFW versus non-MFW funds.
B. MFW funds may not be utilized to upgrade fixtures or other construction materials solely based on aesthetic qualities or personal preferences when lower cost fixtures or materials can provide the same or similar functional benefit to the person.
C. EMSP's may not provide any materials/services not in the original approved bid.
D. MFW funds cannot be used to repair environmental modification upgrades or other augmentations to environmental modifications when MFW funds did not cover the original environmental modification.
E. Any augmentation or upgrade to the MFW funded portion of the environmental modification may void any warranties in place.

F. When one or more individual(s) in Waiver services, are family members and will benefit from an environmental modification, each impacted participant may equally divide the cost of the environmental modification from their respective ISP budget.

CHAPTER 17
VEHICLE MODIFICATION SERVICES

Vehicle Modification includes the purchase or installation of equipment and/or making physical adaptations or alterations and cost of maintenance for the adaptation or alteration, to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

All services must be provided in accordance with applicable federal, state, and local vehicle codes.

Vehicle Modification is available to a person of any age and is coordinated with the person, guardian, Nurse Case Manager (CM), licensed providers and members of the IDT as necessary to ensure quality of service and meet the standard requirements.

I. SCOPE OF SERVICES

A. Vehicle Modification consist of installation, repair, maintenance, training on use of the modifications and extended warranties for the modifications. The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of services.

1. Examples of Vehicle Modification include the following modifications of the vehicle, the accompanying purchases as well as the necessary installation services:
    a. automatic door opener;
    b. installation of wheelchair ramps;
    c. wheelchair or scooter lift;
    d. wheelchair or scooter carrier;
    e. adaptive seating,
    f. automatic door openers;
    g. changes to the ceiling or floor to allow for a wheelchair or special seating.

2. The following are excluded:

3. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
    a. Purchase or lease of a vehicle; and
    b. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

3. Equipment that is covered under the State of New Mexico's Medicaid program cannot be purchased under the MFW.

II. VEHICLE MODIFICATION SERVICES PROVIDER AGENCY REQUIREMENTS

The Vehicle Modification Services Provider (VMSP) must demonstrate the following:

A. The EMSP must have documentation verifying that the provider and any of the subcontractors utilized are bonded and hold an appropriate mechanic or body work license; appropriate technical certification to perform the modification.

B. VMSP must have a current business license issued by the state, county or city government.

C. The VMSP must demonstrate knowledge and work history showing the ability to interpret, implement and ensure that Federal ADA standards and applicable guidelines are followed in all adaptations when applicable to the person's needs.

III. SERVICE REQUIREMENTS

A. Vehicle Modification Services are available to all qualified participants receiving MFW services.
   1. The need for the Vehicle Modification should be identified in the ISP and supported by a therapy evaluation.
   2. The cost of the Vehicle Modification plus the administrative fee cannot exceed the maximum cost of $5,000.00 every five ISP years.
   3. Vehicle Modifications to the vehicle owned by the person, owned by the guardian, owned by the family must be compliant with the MFW Waiver Standards and should meet the Americans with Disabilities Act (ADA) applicable guidelines when ADA guidelines will also meet the person's functional needs.

B. The CM must obtain a signed Verification of Benefit Availability form from the MFW Manager prior to approval of this service.

C. Pre- Service Requirements
   1. Nurse Case Manager
      a. Informs family that the total allowable expenditure for Vehicle Modifications Services (EMS) is a maximum of $5,000.00 that is available to be added to the MFW budget once every five years. The $5,000 may be used at once or in portions over the 5-year period that begins on the date of Prior Authorization approval. If the planned modification exceeds $5,000.00, the family will be informed that they are responsible for paying all additional costs.
      b. Assures that the ISP reflects the need for VMS to an individual's primary means of transportation.
      c. Coordinates physician order for a Physical Therapy (PT) or Occupational Therapy (OT) home evaluation visit. A physician office visit may also be needed.
      d. Coordinates the PT or OT vehicle evaluation visit through the EPSDT benefit for children or Medicare/Medicaid benefit for adults. The MFW therapy benefit for adults is the payer of last resort for this evaluation. If it is necessary to apply the MFW therapy benefit for this evaluation the CM provides the person with a Secondary Freedom of Choice (SFOC) form to select a MFW therapy provider.
      e. Provides the person/family with a Secondary Freedom of Choice (SFOC) form to select a MFW Vehicle Modifications Services Provider (VMSP)
      f. Supports ongoing communication between the family, VMSP and the therapist as needed.
   2. Therapist
      a. The OT or PT completes the evaluation of the vehicle, develops and provides recommendations and supporting documentation as needed for the Vehicle Modifications to the family and CM, and EMSP.
      b. Any authorizations for additional consultation services related to the Modification will be obtained by the therapist as needed.

3. VMSP
    a. Contacts family to set up a visit and informs the family, CM and therapist of the date and time.
    b. Completes the visit and creates Vehicle Modification plan based on input from the person/family, CM and therapist.
    c. Finalizes plans with person/family and therapist to meet the needs of the person in accordance with the MFW Vehicle Modification Standards; federal, state and local building codes.
    d. Submits proposed plan and all costs to the family and the CM within ten business days after first visit with vehicle owner/person/guardian.
4. Service may be provided when CM verifies that all preservice requirements are met, and person/family/vehicle owner accepts the plan and all required documents are present.
5. The VMSP completes all proposed work in compliance with the plans and to the satisfaction of the person/family.
6. After work is completed, the family signs and dates the original Vehicle Modification plan, from the VMSP, verifying the satisfactory completion of work.
7. The VMSP provides copies of the final signed form to the family, CM and the MFW Manager within 5 business days of signature.
8. The VMSP retains the original forms for their files
9. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

D. VMSP SERVICE REQUIREMENTS
1. Obtains a copy of the secondary freedom of choice.
2. The VMSP must coordinate planning for the environmental modification with the CM, the person/ guardian/ family, as applicable and the therapist who conducted the vehicle assessment.
3. The VMSP must coordinate with the therapist and/or qualified person who provided the assessment to acknowledge, document and assure planned modifications will meet the person's clinical and functional needs:
    a. Coordination should occur at an in-person or by email or phone.
    b. If in-person on-site coordination cannot occur or if this is not needed because the planned modification is very minor, coordination can occur via e-mail or phone with MFW Manager approval.
    c. Both the evaluator and the VMSP should document what was agreed upon regarding the Vehicle Modification Plan during this meeting or through alternate communication.
    4. The VMSP must develop an assessment of the vehicle and the scope of work needed to complete the modification.
    5. The VMSP must provide an itemized price quote to the CM within ten business days after first visit with homeowner/person/guardian.
    6. The VMSP must provide or secure certified contractor(s) or vendor(s) to provide the installation or modification services.
    7. The VMSP must ensure that proper mechanical operation and design criteria are addressed in planning of the adaptation.

8. The VMSP must interpret necessary modification or mechanical procedures to the person, guardian, vehicle owner or other family members, CM, and Provider Agencies and DDSD prior to construction activities.
9. The VMSP must provide administrative and technical oversight of mechanical or modification projects.
10. When requested, the VMSP must provide consultation to the person, guardian, vehicle owner or family, CM, and DDSD concerning environmental modification projects to the person's vehicle prior to or during modification activities.
11. The VMSP must ensure inspection of the final environmental modifications to ensure:
    a. compliance with all local, state, and federal codes and requirements
    b. the adaptation (s) meet the approved plan submitted for vehicle adaptation.
12. The VMSP must meet reasonable timelines for completion of vehicle modifications.
13. The VMSP must contact person/guardian/homeowner within one business week of being notified of the signed SFOC to schedule the initial consultation.
14. The VMSP must complete all modifications within six weeks of the approved budget. A waiver of this time-line must be sought from DDSD if extraordinary circumstances prevent the VMSP from meeting this requirement.
15. The VMSP must review accuracy of modification costs submitted by sub-contractors, if applicable.
16. The cost of the Vehicle Modification and administrative fees cannot exceed the maximum cost of $5,000.00 every five ISP years. Administrative costs of the Vehicle Modification Service Provider (VMSP) will not exceed fifteen percent (15%) of the total cost of the modification project managed by the Provider Agency.
17. The VMSP must provide a minimum of a one-year written warranty of the work completed, including both materials and labor, to person, guardian, family, vehicle owner and CM.
18. Withholding or denial of final payment may occur if the person in service or his/her guardian files a dispute to the MF Waiver Manager regarding the quality of work and the MFW Manager agrees with the complaint.

E. Cost of Materials:

1. Materials utilized in projects must be of Medium Grade and meet industry construction standards while considering the personal preferences of the homeowner.
2. MF Waiver funds may not be used for upgrades in materials that do not offer functional benefits to the person.
3. Purchase receipts for all materials must be kept in the VMSP file and must be furnished to the CM.

F. Documentation for Vehicle Modification Services will be maintained by the MF CM. The VMS documentation will include: ISP section related to the need/goals for the VMS, the DDSD Benefit Verification form, the therapist's VMS Evaluation, secondary freedom of choice form(s), VMS Plan, VMSP detailed cost report and documentation of work completion and acceptance/satisfaction by the individual/guardian/vehicle owner.

G. VMS documentation will be retained by the CM program and provided to the MFW Manager upon request.

IV. USE OF FUNDS

A. Cost estimates, items and project plans are required to specifically identify the materials to be purchased and the labor costs associated with the expenditure of MFW versus non-MFW funds.
B. MFW funds may not be utilized to upgrade fixtures or other construction materials solely based on aesthetic qualities or personal preferences when lower cost fixtures or materials can provide the same or similar functional benefit to the person.
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