AUTISM TREATMENT ASSISTANCE PROGRAM

Policy Manual, Chapter 2100

AGING AND DISABILITY SERVICES DIVISION

2101 INTRODUCTION

Nevada's Autism Treatment Assistance Program (ATAP) was created to assist parents and caregivers with high costs associated with autism-specific treatments for children diagnosed with autism spectrum disorder (ASD) (NRS 427A.875). The program provides temporary assistance and funding to pay for evidence-based treatments including Applied Behavior Analysis (ABA), Verbal Behavioral (VB), and Pivotal Response treatment (PRT) to increase useful behaviors and reduce those that may be harmful or that interfere with learning, to bring about meaningful behavior change.

2101.1 GENERAL PROVISIONS

ATAP is a statewide program that provides a monthly funding allotment to contracted community providers on a service agreement (SA) (hereafter referred to as CP) for ongoing treatment development, supervision, and a limited number of weekly intervention hours based on a child's individual treatment plan, age, and income. Covered services include:

- Daily intervention hours
- Development and supervision
- Essential tools, supplies or equipment
- Occupational, physical and speech therapy (when other payment sources do not provide coverage)
- Program training
- Targeted Case Management

2110 ELIGIBILITY AND INTAKE

Families must use CPs that are approved by their insurance or Nevada Medicaid. ATAP is the payor of last resort, therefore applicants with Nevada Medicaid must select providers currently enrolled as Nevada Medicaid providers. However, such applicants with Nevada Medicaid accessing ABA through a non-Medicaid provider may be eligible for ATAP service coordination only if that specific service is not met by another agency (e.g., ADSD Developmental Services Regional Centers (RC) or Nevada Early Intervention Services (NEIS).

2111 REFERRALS

Referrals are accepted from a diagnosing provider, state agency, community service providers, and/or parent self-referrals. Referrals may be received online using the ATAP Referral tool (ATAP-EI-10), via fax, mail, or by phone. The following information is required in the referral form:

- Diagnosis Date;
- Parent/Child Contact Information;
- Referring Agency/Person;
- Insurance Information; and
- Signed Consent.

2112 PROCESSING REFERRALS

Intake staff are the first point of contact for referrals and are responsible for assisting families and/or designated authorized representatives (AR) with inquiries and referrals. If a referral is submitted as incomplete but includes contact information, the intake staff will make contact to complete the missing information and process the referral. Completed referrals will be processed within five (5) business days.

2112.1 INITIAL CONTACT

Intake staff will make contact using the information provided in the ATAP referral to conduct a phone interview with the applicant. The intake staff will make no less than three (3) attempts to contact the applicant by phone for an intake interview, allowing one (1) calendar week between each attempt. Intake staff will leave a voice message and follow up with an encrypted email at each attempt when unable to reach the applicant. If applicable, the intake staff will also inform the referring provider of any challenges with communication. If no contact is made after the third (3rd) attempt, a Notice of Decision – Denied/Closed (ATAP-EI-01) will be issued.

If a referral is received and has an existing record it will be re-opened, and the Information and Referral (I&R) details will be updated in the existing record.

2112.2 INTAKE INTERVIEW

Upon contact with the applicant, an intake interview is conducted to identify and request required documents for eligibility. During the interview, the applicant is informed of available service options, the philosophy of the agency, and their individual rights.

If the applicant on the referral has an active service plan for a sibling, the intake staff will document the active sibling's status in the I&R section of the designated electronic system of record and will discuss this information with the family during the intake interview.

The intake staff will document the interview in the designated electronic system of record and mail the ATAP application (ATAP-EI-04) with the associated required documents (see manual section 2114, Required Eligibility Documents) for the applicant to complete and return within 30 calendar days. The intake staff will also provide the following informational materials:

- ADSD Notice of Privacy Practices (GA-CI-02);
- ADSD Acknowledgement Privacy Practices (GA-CI-03);
- State of Nevada Voter Registration Inquiry Form; and
- State of Nevada Voter Registration Application (available via the Nevada Secretary of State Office website).

Applicants must return a signed Acknowledgment Privacy Practices (GA-CI-03) confirming receipt of the ADSD Privacy Practices along with their completed application.

All referral activities, contact attempts, and information will be documented in detail in the designated electronic system of record.

2113 ELIGIBILITY CRITERIA

ATAP applicants must meet the following eligibility criteria:

- Be a United States citizen or a qualified alien as defined in 7 CFR 273.4(a)(6)(i).
- Reside in the State of Nevada.
- Be under the age of 20.
- Have a diagnosis of ASD from a qualified professional, including a physician, psychologist, child/adolescent psychiatrist, pediatric neurologist, or other qualified specialty; and
- Meet financial eligibility under 300% of the annual Federal Poverty Guidelines (FPL).

Applicants who fall under 300% of the FPL must apply for Nevada Medicaid if not already approved. Applicants who do not have insurance or who have been denied coverage by Nevada Medicaid may qualify for ATAP assistance based on financial eligibility, as determined by the federal poverty level and applicants' income.

2113.1 AUTISM DIAGNOSIS

Diagnosis must be provided by a qualified professional (see manual section 2113, Eligibility Criteria). Supporting documentation must include, but is not limited to:

- A description of Developmental Delays.
- Detailed behavioral observations.
- Results from accepted, normed instruments indicating a high probability of an ASD diagnosis. Diagnostic reports should clearly include the names and scores of all administered tests or protocols.

If a diagnosis is required, intake staff will provide the applicant with a list of providers in the state who are qualified to diagnose ASD. The list is also available on the ADSD website at ADSD.NV.GOV.

Educational assessments conducted by a certified school or educational psychologist may be used to inform the confirmation of a diagnosis. Proof of eligibility may include:

- A current Individualized Family Service Plan (IFSP).
- An Individual Education Program (IEP).
- Multidisciplinary Team (MDT) report from the school district or early intervention services.
- A copy of the formal diagnosis report.

Additionally, diagnosis reports must include the results from an adaptive behavior assessment, which must involve one (1) or more standardized instruments.

2113.2 FINANCIAL ELIGIBILITY

Applicants must meet financial eligibility requirements based on gross annual income and household size. The total family gross household income must be less than 300% of Federal Poverty Level (FPL) Guidelines. If the family's gross income is more than this amount, a funding reduction will be applied to the total eligibility for funding. Families who do not meet 300% FPL are not reviewed for a reduction.

This includes earned and unearned income for all individuals living in the household excluding the individual's Supplemental Security Income (SSI). SSI benefits or adoption subsidies received by other members of the household are not excluded. The program considers:

- All members of the household (e.g., single, married, filing separately, head of household);
- All sources of income that contribute to the house; and
- Deductions for out-of-pocket medical expenses.

Applicants enrolled in Nevada Medicaid are exempt from income verification requirements. Applicants not receiving Nevada Medicaid must submit current (within 30 calendar days of application date) income and medical expense documentation for all household members. Acceptable forms of verification include tax returns, pay stubs or other official documentation for:

- Alimony;
- Child Support;
- Gambling Winnings;

- Supplemental Security Income (SSI); or
- Work Income.

The Annual Funding Disclosure form (ATAP-EI-06) is used to determine funding amounts.

If an applicant has primary insurance that does not cover ABA services and does not have Nevada Medicaid, ATAP requires an annual denial letter from the insurance provider to determine eligibility for a straight ATAP-funded plan.

2113.2.1 Funding Reductions

Applicants will be notified of any funding reduction applicable with the Notice of Funding Reduction (ATAP-EI-09) within five (5) business days of determination.

If a funding reduction is determined appropriate and there are multiple siblings enrolled in the program, the reduction will be applied to all siblings with total reduction split equally between them.

Applicants must qualify for minimum monthly assistance from ATAP as defined in the rates sheet on the ADSD webpage.

2114 REQUIRED ELIGIBILITY DOCUMENTS

A completed ATAP Application (ATAP-EI-04) must be submitted along with all required documents to determine eligibility. All submitted documentation must reflect a 30-calendar day period prior to the date of the application date.

2114.1 ATAP PROGRAM DOCUMENTS

The application packet must include the following program documents for eligibility:

- ATAP Application Checklist (ATAP-EI-02);
- Eligibility Determination Standards (ATAP-EI-03);
- ATAP Application (ATAP-EI-04);
- Authorization to Release or Request Information (GA-CI-01);
- Notice of Privacy Practices (GA-CI-02);
- Acknowledgement of Privacy Practices (GA-CI-03);
- Treatment Priority Worksheet (ATAP-EI-05);
- Financial Disclosure Document (ATAP-EI-06)
- Medicaid FA-11F Form (if applicable); and

- State of Nevada Voter Registration Inquiry Form and Voter Registration Application as found on the Nevada Secretary of State Office website.

2114.2 IDENTIFICATION

Proof of identity may be verified with the following items (not all-inclusive):

- Birth Certificate;
- Driver's License;
- Military Identification (ID) (active, retired, reserve, dependent, etc.);
- United States Passport or Certificate of Naturalization;
- Social Security Card or Number; or
- State Identification (ID) Card.

2114.3 CITIZENSHIP

Applicants must provide proof of U.S. citizenship, have a legal immigration status as a qualified alien, or U.S. Lawful Permanent Resident (LPR) status. Acceptable documents include those listed in Manual Section 2114.2, Identification; hospital or public health birth records; Tribal census papers; or U.S. Citizenship and Immigration Services documents (e.g., Naturalization Papers, I-551 Permanent Resident Card, I-94 Arrival/Departure Record).

2114.4 NEVADA RESIDENCY

Verification of Nevada residency is required at each application or anytime a change in residence occurs. For children under the age of 18, documentation must demonstrate that the child's parent or legal guardian resides in Nevada. Residency verification must include the applicant's name and physical address and must be dated within 30 calendar days of application. Acceptable sources (not all-inclusive):

- Utility statements or receipts (e.g., electric, gas, phone);
- Employer's statement or records;
- Rent/mortgage receipt;
- Child Protective Services (CPS) or foster care placement letter for the child; or
- Valid Nevada Driver's License or State Identification Card.

2114.5 HEALTH INSURANCE INFORMATION

Applicants must also provide a copy of both sides of their health insurance and/or Nevada Medicaid identification card.

2115 PROVIDER SELECTION

Applicants are given provider choice from a list of CPs contracted with ATAP. The CP list is updated frequently and is organized by provider and region.

ATAP may offer recommendations for CPs based on provider availability, the child's age and specified areas of need, and the applicant's communicated preferences. ATAP does not assign CPs to applicants or participants.

Applicants must be with an ATAP CP to be eligible for ATAP funded support, including:

- Learning materials.
- Alternative and Augmented Communication (AAC) devices.
- Parent training; or
- Translation services.

2115.1 INSURANCE & PROVIDER SELECTION

Primary insurance covering ABA services has the following impact on provider selection. If the applicant has:

- Primary insurance covering ABA; services must be obtained from an ATAP contracted CP who is in-network and is authorized by the insurance company. OR;
- Primary insurance covering ABA with Nevada Medicaid as secondary insurance; services must be provided by an ATAP contracted provider who accepts both the primary insurance and secondary Nevada Medicaid insurance. OR;
- Primary insurance not covering ABA, with Nevada Medicaid as secondary; services must be accessed through Nevada Medicaid and provided by a CP contracted with both Nevada Medicaid and ATAP.

2116 APPLICATION PROCESS

The completed application and required documents (see Manual Section 2114, Required Eligibility Documents) must be submitted to ATAP within 30 calendar days for review and to determine eligibility. Applicants may request an extension if additional time is needed. No more than one (1) extension (30 calendar days) will be granted, unless otherwise approved by intake staff.

Upon submission, intake staff will review the application for completeness. If additional documentation (including assessments and medical records) is required, the applicant will be notified via the Notice of Decision – Pending (ATAP-EI-08) and a follow-up phone call. The applicant is responsible for obtaining and submitting the requested information.

If documentation for an autism diagnosis is unavailable, assistance will be provided to the applicant in obtaining necessary assessments or supporting documentation. This may include a request for protected health information and/or referrals to appropriate diagnostic or assessment providers.

At the applicant's request, intake staff may conduct a home visit to assist with the application process. During the visit, the following topics are reviewed:

- Application documents;
- Potential plan type options;
- CP information;
- ATAP's waitlist policy and process (see manual section 2117.1, Waitlist); and
- Program and participant expectations.

Intake staff will also gather information about the home environment and the applicant's specific needs, provide referrals to external resources, and offer guidance regarding SSI or Nevada Medicaid enrollment if applicable. Additional support may include:

- Contacting insurance providers to verify benefits or obtain denial letters.
- Assisting with provider outreach to initiate intake or join waitlists.

All application-related activities, including the receipt, home visit, and processing, are documented in the designated electronic system of record.

2117 ELIGIBILITY STATUS

Following review of the application packet and required documentation, intake staff will issue an appropriate notice of eligibility status (e.g., pending, eligible or denied) to the applicant.

2117.1 WAITLIST

The waitlist is a list of eligible participants pending the start of program services. ATAP utilizes a waitlist while waiting for provider availability, caseload availability, and sufficient funding based on plan type. ATAP CPs may or may not use a waitlist based on their own company policies.

An applicant's placement on the ATAP waitlist is determined by applicant risk assessment score, available funding, provider capacity, and caseload availability. Applicants in waitlist status are not eligible for ATAP funding.

2117.2 RISK ASSESSMENT

Intake staff complete the risk assessment in the designated electronic system of record on the same day the applicant is placed on the waitlist. The assessment is scored

automatically in the system and identifies the applicant's immediate needs using specific indicators. This information supports prioritization efforts to reduce wait times.

The waitlist is reviewed weekly to assign families based on waitlist date and risk score. The intake staff will mail out a Notice of Decision - Pending (ATAP-EI-08) within five (5) business days of assignment. If multiple applicants fall withing the High-Risk category, priority is given to the applicant who has waited the longest, even if their score is slightly lower.

2117.3 WAITLIST ACTIVITIES

Intake staff remain the primary point of contact for applicants on the waitlist and are responsible for performing quarterly check-ins to update application details, including provider waitlist status, insurances changes, income updates, and any other relevant information.

2117.4 LOSS OF CONTACT OR NO CONTACT

If contact is not established during a quarterly check-in A voicemail and an encrypted follow-up email are sent requesting a return call within 30 calendar days. If no response is received, a second (2nd) attempt is made, giving the applicant an additional two (2) calendar weeks to respond.

If there is still no contact, a third (3rd) and final attempt is made.

If the applicant does not respond to the third (3rd) and final attempt, the waitlist placement will be closed (see manual section 2117.1, Waitlist). The intake staff will issue a Notice of Decision – Denied/Closed (ATAP-EI-01) within five (5) business days to inform the applicant of the closure.

Quarterly checks and attempts must be documented in the electronic system of record.

2117.5 RESPONSIBILITIES FOR COMMUNITY PROVIDER WAITLIST

Parents/guardians are responsible for contacting CPs and maintaining open communication regarding the provider's waitlist status (if applicable), and the applicant's position on their waitlist.

If no immediate availability exists, applicants must be placed on at least three (3) CP waitlists.

2117.6 ELIGIBLE

Intake staff will project the participant's care plan type based on:

- Age.
- Assessment scores.
- Recommendations from the ABA provider; and

- Insurance status.

Final determination of the care plan type and budget is made by the assigned developmental specialist (DS) upon the participant's transition from the waitlist to start services.

Eligibility is continuously evaluated by the DS through quarterly and annual review of services, which consider service utilization, applicant and participant compliance, and ongoing service needs.

2117.7 NOT ELIGIBLE

An applicant may be deemed not eligible for the program if they:

- Do not meet established eligibility criteria.
- Fail to comply with program requirements.
- Do not complete required assessments; or
- Do not respond to requests for documentation within 60 calendar days from the date of request.

Intake staff will issue a written Notice of Decision – Denied/Closed (ATAP-EI-01), including appeals information (see manual section 2135, Appeals) to the applicant within five (5) business days of the determination. All actions are documented in the electronic system of record.

2118 CASE ASSIGNMENT

Once an applicant is deemed eligible and caseload capacity and/or funding is available, the case is assigned to a DS in the applicant's region.

If regional caseloads cannot be supported due to staffing limitations, eligible applicants (hereafter referred to as participants) may be temporarily assigned to a DS in a different region. In such cases, services are provided via telehealth using Health Insurance Portability and Accountability Act (HIPAA) compliant platforms. The assigned DS must maintain the same standard of service regardless of participant location. When regional caseload capacity is available, participants are reassigned to a DS within their geographic area. The DS is notified of the reassignment and receives the case file when the assignment is active.

Intake staff will issue a Notice of Decision - Eligible (ATAP-EI-07) to inform them of their assigned DS and projected care plan type.

2120 CASE MANAGEMENT

ATAP offers service coordination (case management) through the assigned DS. This service includes coordination of program-funded therapies and linkage to services offered by other agencies within the community. The goal is to support the participant, their family, and the contracted CP in achieving individualized treatment goals.

Case management is provided throughout the life of a case and involves a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy. The purpose is to meet the participant's needs and support optimal outcomes. Case management supports (not all inclusive):

- Referrals to community resources and services.
- Linkage to CPs.
- Development and coordination of specific neuro-developmental and behavioral management goals as identified by the CP.
- Identification, development, and coordination of participant needs related to community resources (e.g., monitoring SSI, IEP support, locating CPs), including face-to-face visits in the natural environment.
- Monitoring provisions and quality of services.
- Ongoing review of continued eligibility for ATAP services.

2121 INITIAL VISIT

The DS must contact the participant or parent/guardian within three (3) business days of assignment to schedule the initial home visit, discuss the ATAP care plan, and provide contact information.

The initial visit should be completed in person whenever possible. If an in-person visit is not feasible, the DS must provide all initial documents electronically or via United States Postal Service (USPS) mail. These documents will be reviewed during a telehealth visit.

Prior to the initial visit, the DS will complete an electronic case file review for completeness, confirm inclusion of all necessary application documents, and verify the signed Authorization to Release or Request Information (GA-CI-01).

The DS must also review the following documents with the participant and parent/guardian:

- Parent Handbook (ATAP-CM-03);
- Acceptance of Support Services and Rights (ATAP-CM-02);
- Autism Treatment Evaluation Checklist (ATEC) (ATAP-CM-05) assessment questions; and

- Annual Care Plan questions from the designated electronic system of record.

All assessment scores, care plan documents, and case notes must be entered into the ATAP designated electronic system of record.

Any follow-up visits required to complete documentation must be scheduled within five (5) business days from the date of the initial visit.

2122 EVALUATION AND ASSESSMENT

ATAP uses multiple tools to assess and determine participant support needs both at the onset of services and throughout the duration of program participation.

2122.1 AUTISM TREATMENT EVALUATION CHECKLIST

The ATEC (ATAP-CM-05) is used to measure changes in a participant resulting from interventions supported by ATAP's services.

The ATEC must be completed by the DS to identify deficits and areas of need based on responses from the participant and parent/guardian across multiple domains. Initial (baseline) ATEC scores are compared to subsequent ATEC scores to evaluate whether services have led to improved outcomes for the participant's identified needs.

The ATEC is also administered annually as part of the program's annual review process. Scores are recorded in the electronic case management system for reporting purposes and to help identify areas where additional support or resources may be necessary.

2123 CARE PLAN DEVELOPMENT

The DS assists the participant and parent/guardian in developing a care plan based on assessment results, parent/guardian input, and recommendations from the ABA provider. The care plan outlines specific goals and benchmarks to be addressed during the treatment period. Treatment is delivered by a contracted CP.

Care planning is a continuous process that evolves throughout the life of a participant's case.

2123.1 REVIEW SERVICE PLAN PROPOSAL AND PRIOR AUTHORIZATION

The DS reviews the CP's service plan proposal and/or the insurance prior authorization/treatment plan. This review ensures that:

- The concerns of the parent/guardian are being addressed;
- Proposed service hours align with the approved care plan type;
- The budget is accurate with ATAP care plan requirements; and

- Insurance authorization details, including service dates, are provided (if applicable).

Time spent reviewing the proposal is documented as a case note in the designated electronic system of record. The entry must be categorized under the appropriate activity (see Case Note Entries Job Aid ATAP-CM-JA-01).

2123.2 WRITTEN CARE PLAN

The DS is responsible for developing the written care plan (see manual section 2125, Plan Types) through gathering information from the assessment documents, meetings with the CP, communication with the parent/guardian, and quarterly or annual reviews (when applicable).

The ATAP person centered plan, in the ATAP designated case management system, is deemed the written care plan.

The care plan is shared with both the parent/guardian and CP and outlines the participant's goals for the care plan year, and funding and support to be provided by ATAP. The written care plan must include:

- All results from the participant's assessments;
- Provider baseline assessment costs;
- Baseline assessment date; and
- Participant's IEP if available.

The care plan assessment is written for a one (1) year period or to align with the participant's annual start date. The completed care plan must be submitted to the supervisor for approval. If the participant is expected to exit the program during or at the end of the planned year, the information must be included in the written care plan.

2124 MONITORING AND FOLLOW UP

Monitoring and follow-up activities ensure that the care plan is effectively implemented and continues to meet the needs of the participant and parent/guardian. These activities may involve adjustments to the care plan (see manual section 2125, Plan Types) and services, and may be conducted through face-to-face visits, phone calls, encrypted email, or telehealth.

These duties may qualify for Targeted Case Management (TCM) following Medicaid Services Manual (MSM) Chapter 2500. Monitoring and follow-up tasks performed by the DS include the responsibilities outlined below.

2124.1 MONTHLY CONTACT

The DS is required to communicate with the primary parent/guardian no less than once per calendar month for each participant on their caseload. If the initial attempt is unsuccessful, the DS must make no fewer than three (3) attempts to establish contact within the calendar month. If the DS becomes unavailable for an extended period, monthly contact responsibilities are delegated to designated staff.

The DS must document the monthly contact in a case note, to include:

- The status of the ABA therapy and service delivery;
- Any changes to the participant's health insurance coverage or status;
- Any changes in household members (e.g., new birth, marriage, divorce, turning 18);
- Any changes in household income or employment (e.g., raise, change in hours, new job, loss of job); and
- AR specific concerns or questions for the ATAP DS.

All monthly contacts must be recorded in the designated electronic system of record, as outlined in Manual Section 2140, Electronic Records. Any updated information must be reflected in the participant's profile as it becomes available.

2124.2 QUARTERLY REVIEWS

The purpose of the quarterly review (QR) is to provide program with progress data for participants, confirm ongoing program eligibility, identify and/or define any necessary plan changes, and provide the participant and their parent/guardian with relevant resources for current services.

QRs are required for each participant on their caseload and must be completed in person. Telehealth may be used under special circumstances with prior approval from the supervisor or designated staff.

All QR visits should be pre-scheduled, preferably with the family. If the DS is unable to reach the family, the visit may be scheduled with the service provider. If the visit coincides with a supervision or workshop session, it must be scheduled before or after the session to avoid disruption of the provider's allotted service time.

During the quarterly review, the DS will review:

- Intervention, supervision, and parent training hours.
- Parent goals.
- CP's progress report.

- Programming through AR feedback or prescheduled DS observation during therapeutic sessions.
- Copies of the quarter's Explanation of Benefits (EOB), if applicable to the care plan.

The DS must complete the Treatment Plan Review (ATAP-CM-06) while reviewing the report. The review form is submitted to the supervisor for review of participant progress. The DS will also address any concerns reported by the parent/guardian and provide additional resources requested during the review or monthly contact.

The DS will document the QR assessment in the participant's electronic case file following the template in the electronic system of record. QR visit activities will also be documented as a case note entry (see manual section 2140.2, Case Notes).

The QR schedule for participants is determined either by the insurance renewal dates or an annual schedule based on the month the participant was moved to active status and assigned to a DS. For example:

- Insurance Plan Year runs January 1 – December 31st; QR schedule is every fourth (4th) month (April, July, and October).
- Participant's Active Status Start Date was assigned a DS and active 09/01, the participant care plan year runs September 1 – August 31st; QR schedule is every fourth (4th) month (December, March, June).

The DS must complete a Case File Review (CFR) prior to the QR meeting to ensure that all required documents and signatures are up to date. If any documents are out of date, the DS must obtain updated documents from the parent/guardian during the QR meeting. At the time of the CFR, the DS will request a progress report from the CP, as required by the participant's plan type. For participants with insurance plans, progress reports must follow the insurance company's reporting schedule.

Progress reports must be submitted to the DS no later than the 15th business day from the original request date

Invoiced hours and the hours detailed on progress reports are reviewed by the DS to confirm compliance with the prescribed hours of therapy by the CP, and to ensure proper utilization of at least 70 percent of the prescribed treatment hours.

2124.3 ANNUAL REVIEWS

The DS must complete an annual review with the parent/guardian and CP for every 12 months of services rendered. Annual Reviews are considered the fourth (4th) quarter review of the year and include a detailed CFR of the previous quarters in the care plan year, and a review of the annual progress report of goals issued to ATAP from the CP. The annual review follows the same process as the quarterly review outlined in manual section 2124.2, Quarterly Reviews (except for the review period).

If the participant has an open case with ADSD Developmental Services, attendance at the annual RC review should be planned.

2124.4 ADDITIONAL VISITS

If a participant requires support outside of the regularly scheduled review visits (e.g., addressing immediate concerns, gathering documentation, or attending an IEP meeting), the DS may conduct additional visits to the home or school. Telehealth is an acceptable alternative when in-person visits are not feasible.

2124.5 STAFFING CASES

Staffing a case is the process of exchanging information regarding a participant while obtaining consultation from other professionals (e.g., providers, peers, supervisors). Examples of staffing activities include, but are not limited to:

- Changes in care plans, and coverage. If there are changes in insurance coverage, the DS may be required to request insurance explanation of benefits from the parent/guardian as directed by supervisor staff.
- Challenging or unique case situations.
- Support services and resources.

2124.6 RESOURCE AND REFERRAL

The DS is responsible for making referrals and providing detailed community resources to parents/guardians depending on their needs Resource and referral activities (not all inclusive):

- Assisting the ATAP participant with immediate care needs for external services, including researching treatment options.
- Referring new participants to an ATAP contracted assessment provider.
- Facilitating visits to outside agencies, CPs, or community events.

2125 PLAN TYPES

All case management duties are centered around the services specified in the written care plan. The plans consider the assessment of the child, the assessment of the parent/guardian needs, and their ability to contribute to the plan.

All term limits for ATAP plan types are cumulative. Total funding approval amounts vary based on the provider's proposal, the child's insurance status, financial eligibility and care plan type. See the program rates found on the adsd.nv.gov webpage for all plan type approval amounts. The Care Plan Overview (ATAP-CM-07) is also an informational resource on all care plan types. Fully funded plan types are for participants who require full ATAP funding. The maximum monthly allowance is determined by the

parent/guardian's monthly income and may be subject to funding reductions based on financial eligibility as outlined in manual section 2113.2, Financial Eligibility.

All plan types below require the following (unless otherwise specified):

- Supervision services completed by a Board-Certified Behavior Analyst (BCBA), Board Certified Assistant Behavior Analyst (BCaBA), or Behavior Consultant pursuing certification contracted with ATAP.
- One-on-One ABA intervention services provided by Registered Behavior Technician (RBT) under the supervision of a BCBA, BCaBA or Consultant contracted with ATAP.
- Progress demonstrated by the participant across all targeted domains indicated in treatment plans, as reported by the BCBA or BCaBA quarterly.
- Parent training conducted by a BCBA, BCaBA, or Behavior Consultant.
- Parent/guardian to report on parent goals through conversation and monthly contact communications with the DS.
- Report writing billable to ATAP at one (1) hour per month. Reports are submitted to the program by the CP following the quarterly review schedule (see manual section 2124.2, Quarterly Reviews) or as required by the insurance reporting period.
- Available for all participants from birth up to age 20, except for the Comprehensive Plan (see manual section 2126.1, Comprehensive Plan).
- All care plan types have a term limit of eight (8) calendar years total service unless otherwise specified (see manual section 2174, Special Considerations).
- Therapeutic services must be completed by appropriately credentialed providers working within the scope of their licensure.

2126 HIGH INTENSITY TREATMENT PLANS

These are behavior plans that are broad in scope and allow both intensive and comprehensive intervention for all skill areas and developmental domains that impact the participant and their family. These plans include funding that allows CPs to conduct their own assessments and complete a workshop month for plan writing, rapport building, and goal establishment. The assessment and workshop months can be completed concurrently within the first (1st) month a new participant is enrolled in the plan, or they may be scheduled separately depending on the participant's assessment needs and provider availability.

2126.1 COMPREHENSIVE PLAN

The Comprehensive Plan addresses all possible skill areas across all developmental domains, including:

- Language/Communication;
- Cognitive Development;
- Adaptive Behaviors;
- Social/Emotional Development;
- Play; and
- Fine and Gross Motor Development.

This plan provides the most direct RBT intervention hours available under ATAP funding. Eligibility includes participants age nine (9) years and under. Exceptions to the age limit may be granted by ATAP Management.

Approved service hours include:

- 11-18 approved RBT hours per week.
- Six (6) hours of supervision per month.
- Minimum of one (1) hour of parent training per month.
- Maximum plan term limit of four (4) calendar years.

2127 TARGETED BEHAVIOR PLANS

Targeted Behavior Plans are narrower in scope than high-intensity treatment plans and address a selected group of skills that impact the participant and their family. These plans are written to address specific areas, including:

- Crisis Intervention/Behavior Management;
- Selected Behaviors;
- Transitioning Skills;
- Social Skills;
- Occupational Therapy;
- Physical Therapy; or
- Speech Therapy

2127.1 EXTENSIVE PLAN

The Targeted Extensive Plan is intended for participants who do not meet the Comprehensive Plan type requirements. This plan addresses three (3) to 10 skills across the developmental domains identified in manual section 2126.1, Comprehensive Plan.

Approved service hours include:

- Between four (4) and 10 RBT hours per week.
- A minimum of 2.5 hours of supervision per month.
- A minimum of 30 minutes of parent training per month.
- Term limit of two (2) calendar years if the participant's plan services were funded under a comprehensive plan at the initial onset of services. OR
- Term limit of three (3) calendar years if the participant's plan services were funded under an extensive plan at initial onset of services.

2127.2 TARGETED BASIC PLAN

The Targeted Basic Plan addresses one (1) to three (3) specific skills or behaviors in the areas of:

- Daily Living Skills;
- Crisis Intervention; and/or
- Communication.

Treatment is limited and will typically include programs to address skills in one (1) or two (2) developmental domains identified in manual section 2126.1, Comprehensive Plan.

Approved service hours include:

- Up to four (4) RBT hours per week.
- Supervision at a minimum of one and a half (1.5) hours per month.
- Parent training at a minimum of 30 minutes per month.
- Term limit one (1) year if participant's plan services are funded in comprehensive at onset of services, *OR*
- Term limit of two (2) years if participant's plan services are funded in extensive plan at onset of services.

2127.2.1 TARGETED BASIC PLAN SUPERVISION ONLY

The Targeted Basic Plan, Supervision Only addresses one (1) to three (3) specific skills or behaviors in the areas identified in manual section 2127.2, Targeted Basic Plan.

Treatment is limited and typically includes programs targeting one (1) or two (2) developmental domains identified in manual section 2126.1, Comprehensive Plan.

Approved service hours include:

- Supervision services completed by a BCBA, BCaBA or Behavior Consultant
- Minimum of three (3) hours of parent training per month.
- Term limits match those outlined in the Targeted Basic Plan.

2127.3 THERAPEUTIC PLAN

The Therapeutic Plan addresses one (1) to three (3) specific skills or behaviors in the areas identified in manual section 2127.2, Targeted Basic Plan. Treatment is limited and typically includes programs targeting one (1) or two (2) developmental domains.

Approved service hours include:

- One (1) session per week for 1:1 Occupational (OT), Physical (PT) or Speech therapy (ST).
- Optional parent training conducted by the appropriate clinician, based on the service rendered, with frequency determined by the provider.
- Progress demonstrated by the participant across defined objectives, as reported by an OT, PT, or Speech/Language Therapist (SLT)
- Eight (8) year term limit if no other plan type was used while enrolled in ATAP

2127.4 PARENT TRAINING PLAN

The Parent Training Plan is a limited plan developed to provide parent training and education using an approved curriculum. This plan does not include one-on-one RBT hours, but it may coincide with other plan types based on participant's needs, if approved by the Program Manager or designated staff on a case-by-case basis.

Approved service hours include:

- A minimum of 30 minutes per week of supervision by a BCBA, BCaBA, or Behavior Consultant.
- Parent training for at least one (1) target behavior, delivered through an approved curriculum, with training identified in the participant's care plan and completed at least 50% in person.
- A six (6) month term limit, with a maximum payable amount of $120.40 per hour.

2127.5 SOCIAL SKILLS PLAN

The Social Skills Plan is overseen by a Licensed Psychologist, BCBA, BCaBA, Behavior Consultant, Licensed Occupational Therapist (OT), or Speech Language Therapist (SLT) with background and experience teaching social skills to children with autism. This plan allows participants to access social skills curriculum offered by CPs that deliver direct treatments for these targets.

This plan requires:

- One (1) hour per week of social skills training conducted by a Psychologist, BCBA, BCaBA or Behavior Consultant, OT, or SLT, following an approved curriculum with goals and outcome measures; and
- One (1) group session per month, as identified in the participant's care plan, and conducted by the approved provider.

At the two (2) year term limit, the plan is reviewed for continuation or a transition to an alternative plan type.

2127.6 INSURANCE ASSISTANCE PLAN

The Insurance Assistance Plan allows participants to access evidence-based treatments and increase the number of treatment hours by utilizing their primary health care plan provider. ATAP will fund the participant's co-pays, co-insurance, or deductible as listed under participant out-of-pocket costs for ABA therapy. Monthly allotments are determined by the AR's monthly income, insurance co-pay, deductible, and/or coinsurance, based on insurance explanation of coverage details.

Participants with primary insurance covering ABA but are not working with a provider who accepts their insurance, must switch to a contracted ATAP CP who does to remain eligible.

If the participant's insurance changes, or they obtain new insurance accepted by the CP, the provider has 30 calendar days to obtain authorization and begin accessing services through the participant's insurance.

If the participant's insurance changes and is not accepted by the current CP, the provider/family has three (3) months to do one (1) of the following:

- Provider can obtain in-network status with the insurance company.
- Provider can secure a single-case agreement with the insurance company; or
- Participant must switch to a provider that accepts their insurance.

2127.6.1 Insurance Assistance Plan Limitations

This plan type is for participants who have primary and/or secondary health insurance coverage to maximize the use of their insurance benefits.

- Maximum hours allowed by insurance, following approved prior authorization.
- Insurance must assist with service costs through in-network benefits.
- Supervision and parent training must be performed by a BCBA, BCaBA, or Behavior Consultant.
- Annual breakdown of monthly funding aligned with the treatment plan.
- Maximum allotment of up to $8,400/year, for up to eight (8) years.
- Recipients must be eligible to receive no less than $250/month in ATAP assistance to maintain program eligibility (see manual section 2113.2, Financial Eligibility).
- Parents/guardians must provide insurance EOB quarterly and upon request to maintain compliance.

2128 SERVICE COORDINATION PLAN

The Service Coordination Plan is designed for Nevada Medicaid recipients. Under this plan, the provider is required to address all possible skill areas across the developmental domains identified in manual section 2126.1, Comprehensive Plan.

Service coordination plan requirements include:

- Participant's insurance coverage is Medicaid as primary (Medicaid only), secondary, or Katie Beckett.
- Services provided following Medicaid prior authorization approval.
- TCM services as approved by Medicaid.
- No maximum term limit for Medicaid recipients under this plan type.

2129 TRANSITION PLANNING

Transition occurs in ATAP when a participant completes a plan and transitions to the next appropriate plan, or when a participant is exiting ATAP funding. To support this process, the DS will meet with the provider and parent. If applicable, a representative from the potential transitional partner or receiving agency will also attend. Together, they define the transition, timeline, and develop the transition plan.

Transition plans include a systematic reduction in treatment hours and supervision over a defined period. Reduced supervision includes periodic follow-up or observations of the participant across environments to ensure regression is not occurring and parent training continues. A key goal of transition planning is to ensure the parent/guardian has increased capacity to support and maintain the participant's acquired skills. The plan may also include defined collaboration with the receiving agency.

2130 TERMINATION

Termination occurs when an applicant or participant is no longer eligible for services due to failure to maintain eligibility or meet probation requirements.

When termination occurs, intake staff or the DS will advise the parent/guardian and the CP (if applicable) of the termination via the parent/guardian's preferred method of contact.

A Notice of Decision - Denied/Closed (ATAP-EI-01), is completed by the DS or intake staff, based on the status of the individual and will be mailed within five (5) business days of the decision to terminate services.

The notice includes the reason for ineligibility, decision to terminate, and appeal information.

The applicant or participant's case is closed within two (2) business days of the termination date. All prior authorizations and care plans are end-dated and reflect the reason for closure.

2131 PROGRAM EXIT

A case may be deemed appropriate for program exit and closure for the following reasons (not all inclusive):

- The participant no longer meets eligibility criteria (e.g., income, age).
- Participant reaches the eight (8) year term limit.
- The parent/guardian requests case closure (e.g., no longer needs services, moves out of service area).
- The participant is in extended placement in an inpatient facility, incarcerated, or out of state/country for more than 30 calendar days.
- Treatment goals are met; or
- Non-compliance from the parent/guardian.

The DS must communicate with the parent/guardian regarding the decision to close the participant's case and is required to request a home visit for closure to gather exit documents and assessments within five (5) business days of the decision.

2131.1 CLOSURE ACTIVITIES

The DS must do the following within five (5) business days of the decision to close the participant's case:

- Complete the ATEC assessment (if it has not been updated within 180 calendar days) to reflect present levels and areas of concern;
- If the participant is closing with both the CP and ATAP, the DS must request a final closing report from the CP (if available) to demonstrate the participants' behavioral progress and current targets at the time of exit;
- Request the most recent IEP and/or MDT from the parent/guardian;
- Complete the appropriate assessment referral based on the region and send the request to the CP and parent/guardian for their records;
- Support the parent/guardian with scheduling the exit assessment with the contracted assessment provider (if necessary). This assessment is recommended but not required for closure to be completed;
- Make necessary referrals to the appropriate RC, and other outside resources the family may need;
- End date all prior authorizations, care plans, and providers in the designated electronic system of record following the user guides provided by the vendor; and
- If applicable, return the participants' hard case file to the supervisor they report to for record retention.

2130 INDIVIDUAL RIGHTS AND APPEALS

2131 INDIVIDUAL RESPONSIBILITIES

2131.1 CODE OF CONDUCT

The purpose of this Code of Conduct is to provide expectations of all parent/guardians, caregivers and CPs involved in services. Applicants and participants are subject to follow the Code of Conduct to maintain program eligibility.

Disruptive behavior that interferes or threatens to interfere with any of the participant's therapeutic services, by the parent or any other individual in the therapeutic setting, will not be tolerated and may be grounds for termination from the program.

Inappropriate behavior during therapeutic sessions may be (not all inclusive):

- Use of loud, suggestive, or offensive language;
- Threatening staff or service providers in any way;
- Damaging or destroying property;

- Sending abusive or threatening communications such as emails, text messages, voicemails, phone calls, or other written communications (including social media) to anyone within the service team;
- The use of physical, verbal, or written aggression towards another adult or participant, and/or
- The consumption or use of any legal or illegal drugs or alcohol in the presence of children or service providers.

All individuals responsible for the care of the participant should be present, aware, and unimpaired during their participant's session. Parents/guardians are responsible for participating as identified in their designated care plan.

2132 PARENT/GUARDIAN REPORTING RESPONSIBILITIES

Applicants must respond to communication requests within 30 calendar days, not to exceed 45 calendar days if an extension is permitted.

The parent/guardian is required to respond to communications requests within 10 business days from the date the DS attempts to contact.

Parent/guardians must report any changes to income, insurance status, personal information (e.g., phone number, address, household) within 30 calendar days of the change. Failure to meet reporting requirements may lead to probation (see manual section 2133, Terms of Probation) or termination of services.

Parent/guardians should report any concerns regarding services received to their Program DS as soon as practicable. The DS will respond to concerns at the lowest level possible and will escalate to their direct supervisor as appropriate. Parent/guardians may file a formal complaint as described in manual section 2134, Complaints.

2133 TERMS OF PROBATION

ATAP reserves the right to place clients on probation. A participant will be at risk for termination from the program if the following actions occur:

- Failure to meet weekly treatment hour requirements;
- Failure to meet quarterly progress requirements;
- Failure to communicate with assigned DS monthly;
- Failure to contact assigned DS within 10 calendar days after their attempt for monthly contact;
- Parent/guardian non-participation or lack of attendance during training sessions;
- Lack of data to support program progression;

- Work environment is not appropriate to support program;
- Reported violence, threats, or altercations during treatment hours;
- Frequent cancellations with assigned provider or with DS;
- Frequent cancellations made under 24 hours' notice or without notice; or
- Failure to provide annual or quarterly documents within the required timeframe.

2133.1 STEPS OF PROBATION

If the DS and their supervisor determine program eligibility requirements are not met and/or AR is deemed non-compliant, and probation is approved to remediate, the following probationary steps will be taken:

- Verbal warning as the first (1st) attempt for correction;
- Written warning with probationary terms following non-compliance after the verbal warning. The DS, Supervisor, and AR must establish agreed upon terms to bring care plan and services back in good-standing and for continuation of original plan.

Probation period will be determined at the time when probation is administered.

If the AR fails to meet probation requirements, the participant's plan could be revised to support a different plan type, or termination from the program will occur.

A participant is in termination status when they have been found non-compliant and unable to meet program requirements resulting in closure from ATAP's program.

2134 COMPLAINTS

Individuals who have a specific complaint or are unsatisfied with their CP and/or services may submit a complaint to the ATAP program manager. Complaints must be submitted by the complainant as soon as possible, but no later than 30 calendar days after the occurrence.

Upon receipt of the complaint, the ATAP program manager will document the complaint in writing and contact the complainant within 15 business days.

2135 APPEALS

2135.1 APPLICANTS

Applicants found ineligible during any part of the application process are provided a written Notification of Decision – Denied/Closed (ATAP-EI-01) by intake staff within five (5) business days of the date of determination. The notice includes an explanation of the decision and the appeal process.

All applicants (including Medicaid and non-Medicaid recipients) who appeal ATAP's decision must send a written request to appeal to the ATAP program manager within 15 calendar days following the receipt of the notice of decision.

2135.2 PARTICIPANTS

ATAP reserves the right to use probationary terms consistent with the Code of Conduct (see manual section 2131.1, Code of Conduct) for violations. If participants disagree with the decision, they have the right to request an administrative review to establish if the decision is appropriate.

2135.3 RESOLUTION

If the response from the ATAP program manager does not satisfactorily resolve the issue, the complainant may file an appeal in writing with the Deputy Administrator for review. They will direct the review to designated QA staff to review within 15 calendar days of receipt of the request.

Upon receipt of the appeal, designated QA staff will contact the complainant to discuss possible resolutions. At the time of contact, staff may request additional assessment information and/or documentation to review the case. Based on the review, recommendations will be provided to program leadership and the Deputy Administrator within 15 calendar days of the communication with the complainant.

Program and QA leadership will review the recommendation with the Deputy Administrator to make a final determination. Upon decision, designated QA staff will notify the complainant of the result within two (2) business days of the determination.

All communication between ADSD and the complainant will be documented by designated QA staff in the designated electronic system of record within five (5) business days of each interaction.

2140 ELECTRONIC RECORDS

2140.1 MANAGING PARTICIPANT PROFILES

All ATAP staff are assigned an account for the designated electronic system of record following state security requirements.

Staff must ensure all consumer records are accurate. Any changes, including all demographic information, insurance, and provider information, must be updated in the electronic system of record within five (5) business days of notification of the change.

2140.2 CASE NOTES

All DSs are required to keep detailed notes regarding each interaction with program applicants and participants. These notes are a critical component of case management

to support the participant, parent/guardian, and the DS's case decisions throughout the life of the case.

Case notes must remain objective and clearly outline all communication including the date of contact, a summary of conversation, and follow-up actions following the Data, Assessment, and Plan (DAP) note procedures as outlined in the Case Notes Job Aid (ATAP-CM-JA-01). The note must also include details of any tasks a DS completes, the number of units of time it took to complete the tasks or interactions, and the description of billable and non-billable activities (see manual section 2141.1, Direct Time (billable) and 2141.2, Administrative Time (non-billable).

All entries must be recorded in the designated electronic system of record within five (5) business days of the activity, unless otherwise specified. Activities (not all inclusive):

- Reviewing CP assessments, proposals, and progress reports;
- Monthly contacts;
- Visits, including initial, quarterly, and annual reviews;
- Staffing cases or meetings with supervisors to discuss the participant's case; and
- Resource and referral activities.

2141 TARGETED CASE MANAGEMENT DOCUMENTATION

TCM is a billable service for Nevada Medicaid individuals with intellectual disabilities and related conditions following Nevada Medicaid policy (MSM 2500). TCM is an important revenue source to support the ATAP program and is used for program reporting purposes.

Staff must record the total amount of TCM service delivery time completed for billable tasks in the case notes. Staff must use the appropriate case note activity type template by selecting a billable or non-billable service delivery based on the type of service that was rendered See the Targeted Case Management Job Aid (ATAP-ER-JA-01) for details on completing TCM billing and notes.

TCM minutes are tracked as indicated below in accordance with proper billing practices:

- 0 to 7 minutes
- 8 to 22 minutes
- 23 to 37 minutes
- 38 to 52 minutes
- 53 to 67 minutes
- 68 to 82 minutes

To be eligible for TCM reimbursement, applicants must be verified as Nevada Medicaid eligible. ATAP intake staff are responsible for confirming and documenting Nevada Medicaid eligibility for each eligible participant's record.

TCM must be recorded within five (5) business days of completing the activity. Errors recorded in a case note entry must be remedied as soon as identified.

2141.1 DIRECT TIME (BILLABLE)

Direct time refers to activities that considered billable services to the participant, including assessment, development of services plans, monitoring, follow-up, and referral related activities (MSM 2500).

2141.2 ADMINISTRATIVE TIME (NON-BILLABLE)

Administrative time, by contrast, includes non-billable services such as internal coordination or documentation, or for individuals who are not eligible for TCM reimbursement, or are being dually served with ATAP as the secondary program. These activities are non-reimbursable by Nevada Medicaid.

2141.3 SHARED TARGETED CASE MANAGEMENT WITH STATE OF NEVADA REGIONAL CENTERS

When there is a case that has shared participants between ATAP and ADSD's Developmental Services program, the assigned DS must meet with the RC Service Coordinator to determine which of the programs providing services is the lead case manager and to the one authorized to bill TCM.

When ATAP is not the program authorized to bill TCM, the ATAP DS will continue to record the "direct time" service units completed and will mark them as non-billable TCM time in the electronic system of record.

2141.4 MEDICAID AND SOCIAL SECURITY NUMBERS

Federal and state HIPAA and confidentiality regulations safeguard the privacy of individuals served and ensure that any information shared or gathered by the program is used appropriately and, in the individual's best interest. ATAP is responsible for preventing improper disclosure and must share relevant information only with appropriate parties at appropriate times to support service delivery. The DS must follow applicable federal regulations and state statutes, particularly those protecting sensitive identifiers such as Nevada Medicaid and Social Security numbers.

- The Medicaid Number field is required in the designated electronic system of record and must be updated promptly any time the individual's Medicaid benefit status changes
- The Social Security Number is a required field. If an individual applies for services but does not provide their social security number, intake staff will add a

case note documenting that SSN was not provided. This field must be updated at the time the SSN is received.

Cases may be marked “confidential” within the designated electronic system of record, restricting visibility to only the assigned worker(s). This designation is enabled by checking the “confidential” box, which remains hidden until approved by ADSD, program manager, or their designee.

2150 QUALITY ASSURANCE AND COMPLIANCE – RESERVED

2160 PROVIDER INFORMATION

ATAP services are provided statewide where ATAP provides case management and direct services are provided by contracted CPs following state purchasing requirements. Contracted CPs must adhere to ATAP policies and procedures to provide quality services to ATAP participants.

Contracted CPs must follow ADSD ATAP policy and procedures for reimbursement of services provided. Providers must maintain credentials including required licensure through the applicable:

- Nevada Applied Behavior Analysis Board,
- Board of Occupational Therapy
- Physical Therapy Board
- Speech-Language Pathology, Audiology & Hearing Aid Dispensing Board

Providers must also have an active/current Nevada Medicaid Profile.

2160.1 COMMUNITY PROVIDER WAITLISTS

ATAP does not direct or influence CP waitlists and is not authorized to require providers to prioritize ATAP applicants or participants for initiating ABA services within their programs.

2160.2 REPORTING REQUIREMENTS

CPs must provide progress reports to ATAP staff following the specific care plan schedule and/or insurance reporting requirements.

All State of Nevada employees and CPs are mandated reporters and must report any known or reasonable suspicion of abuse and/or neglect of people in their care. (NRS 432B.220)

Additionally, CPs must meet all reporting requirements applicable to their credentials and licensure ethic codes. Failure to meet reporting requirements may result in corrective action as executed in the provider's service agreement.

2170 BILLING AND FISCAL MANAGEMENT

2171 FISCAL MONITORING

Fiscal monitoring is completed to ensure appropriate use of funds in accordance with state law, federal regulations, and division policies. DSs review the weekly caseload report provided by the ATAP Management Analyst (MA) for identifying errors or discrepancies to the care plan details and/or budget. Additionally, invoices for TCM are reviewed by designated billing staff between the 11th and the 15th business day of the month for the previous month's services rendered and are provided to the appropriate DS for correction within five (5) business days.

Designated billing staff complete monthly invoice verifications of all invoices received from CPs for accuracy. Items identified on invoices by the designated billing staff as frequent concerns are reported to their supervisor within two (2) business days of identification. Frequent concerns include, but are not limited to:

- Inaccurately billed hours based on reported start and end times.
- Travel dates and times that do not match.
- CP agency name and address do not match vendor registration.
- Missing name and/or signatures.
- Inaccurate service locations reported.

The supervisor will investigate reported concerns to determine whether the CP requires additional training or support. If additional training is recommended, it will be provided by the program and scheduled with the CP within ten (10) business days or as directed by program leadership.

2172 COVERED SERVICES FOR REIMBURSEMENT

2172.1 PRIOR AUTHORIZATIONS

Prior Authorizations (PAs) are used to establish the exact amounts ATAP can pay CPs for ABA services and any support directly related to ABA therapy. These amounts are determined based on the participant's ATAP care plan type. Because PAs directly impact ABA therapies, CPs, the state budget, and the program budgets, it is essential that the care plan budgets are accurate.

When entering an authorization into the designated electronic system of record, staff must select a service type that clearly reflects the nature of the expenses. This should be either:

- "Baseline Assessment", used for initial assessment costs paid to the CPs, or
- the specific applicable service used for the prior authorization costs.

The DS must draft the PA based on the participant's insurance status, care plan type and the CP's proposed annual budget. The PA must be entered into the electronic system of record within five (5) business days from the receipt of the CP's proposal, or by the end of the month, whichever comes first.

Upon completion, the DSs supervisor is responsible for reviewing the authorization for accuracy and approval.

Any errors in the PA are the DS's responsibility to correct. PAs cannot be removed from the electronic system of record unless approved by program leadership.

If the error was due to a provider oversight, it must be corrected by the end of the current month to ensure the PA accurately reflects approved services.

2172.2 LEARNING MATERIALS

Each participant receiving active services through ATAP is eligible for a learning materials allotment (see rate identified on the adsd.nv.gov webpage) for the duration of their active enrollment. An additional allotment may be approved by program leadership staff on a case-by-case basis.

The CP must submit an itemized list of learning tools directly related to programming goals. This list must be submitted directly to the vendor. Within five (5) business days of notification from the vendor that an order is pending the supervisor will access the request and review and approve/deny the order as appropriate. If items are not approved for purchase the supervisor will direct the DS to contact the CP within five (5) business days to remove the unapproved items. Following approval of the order, the items will be purchased.

The DS must add the exact total in the prior authorization in the system under "Learning Materials" as well as the detailed itemized list. The learning materials authorization will only be available during the month the items were approved to be purchased.

2172.3 ALTERNATIVE AND AUGMENTED COMMUNICATION DEVICES

Each participant approved for ATAP funding may receive an AAC device (see adsd.nv.gov webpage) and an approved AAC software application. Requests must be made by the parent/guardian directly to the CP. The CP must submit a request for the device and AAC software application directly related to the communication goals and targets established in the provider's treatment plan. The request must detail the AAC software application that will be downloaded onto the device, and the total dollar amount

necessary (tax included) for the requested software application. The DS is responsible for reviewing the request and submitting it to their supervisor for approval.

Upon approval, the DS must add the exact total to the PA in the electronic system of record under “Learning Materials”. The prior authorization will only be available the month the AAC was approved to be purchased. The funds for this budget are separate from the learning materials allotment budget specified on the rates page (see adsd.nv.gov webpage).

The CP is responsible for purchasing and setting up the AAC device and software application with the participant’s parent/guardian. The CP is also responsible for training the parent/guardian and treatment team on the use of the device and program for consistency across environments.

The DS must schedule a meeting with the parent/guardian to confirm receipt of the device and application and obtain signature on the AAC Device - Acknowledgement of Receipt Form (ATAP-CM-04).

If an AAC device was supplied by sources outside of ATAP (Medicaid, etc.,) funding for the software application will not exceed the designated rate on the adsd.nv.gov webpage. The provider must confirm AAC software applications are not able to be funded by the original funding source.

The DS is responsible for auditing the AAC device during scheduled visits (quarterly or annually) to confirm compliance with guidelines in accordance with the AAC Device-Acknowledgement of Receipt Form (ATAP-CM-04).

2172.4 TRANSLATION SERVICES

Each participant approved for ATAP funding is eligible for a translation services monthly allotment for the duration of their time in ATAP services (if needed). The monthly allotment rates can be found on the adsd.nv.gov webpage. The CP must submit a detailed request for translation funds directly related to services rendered. The DS is responsible for reviewing and approving the request as appropriate. This service does not require the DS supervisor’s approval.

The DS must add the exact total to the PA in the system under “Translation Services”, as well as the details of the request specifying the translation hours required. This PA for translation services will only be available in the months the translation is approved.

2172.5 INDIVIDUALIZED EDUCATION PLAN REQUESTS

Program participants requiring an IEP are approved for up to one (1) hour of additional BCBA supervision time to allow the BCBA to meet with the school administrator, teachers, and support staff as an additional resource to the family.

The CP must submit an IEP Meeting Attendance Request Form (ATAP-BF-01) to the DS that includes the date and scheduled time of the IEP meeting. This form requires final approval from the supervisor.

The DS must add the additional supervision hours to the PA in the system for the month the IEP will be completed and specify the IEP under in the services line.

2172.6 DETENTION ALTERNATIVE FOR AUTISTIC YOUTH COURT

Program participants requiring Detention Alternative for Autistic Youth (DAAY) court attendance are approved for one (1) hour of BCBA supervision time (per court date) to allow the BCBA to meet with the court and provide regular updates on the participant's progress. The DS will appear in court hearings with the participant, parent/guardian, and the BCBA, and will sign the approved DAAY Court Consultant Attendance Form (ATAP-BF-02) and return it to the BCBA for billing purposes.

The DS must add the additional supervision hours to the care plan budget in the system for the month the DAAY court attendance took place.

The CP must submit the approved DAAY Court Consultant Attendance Form (ATAP-BF-02) to ATAP billing staff when submitting their invoice for payment as verification of the service rendered.

2173 ALTERNATIVE APPROVALS

There may be times when a CP requests additional funding support outside of the traditional funding supports ATAP provides. This support may be approved on a case-by-case basis depending on the program participant’s need, the availability of funding, its relation to ABA therapy and goals, and the CP’s proposal.

Requests must be reviewed by the DS and any research completed to aid in the approval must be recorded as a journal entry in the designated electronic system of record. When the DS receives requests for services from the CP, it is their responsibility to:

- Review the details of each request;
- Provide feedback if a request cannot be approved or request additional information if required; and
- Submit the requests to their supervisor for final approval.

The supervisor is responsible for approving the requests or may forward them to program leadership for additional review and/or approval as needed.

Approval amounts are detailed in the ATAP Program’s Rates Sheet as posted on the adsd.nv.gov webpage. CP requests may include the items described in manual section 2172, Covered Services for Reimbursement.

2174 SPECIAL CONSIDERATIONS

A special consideration is the act of overriding specific criteria of the ATAP care plan requirements. Special considerations can be requested when:

- The cost or limitations of accessing services for the participant through the family's insurance creates a financial hardship for the family;
- The participant has reached the term limit specific to their assigned Care Plan (ATAP-CM-07) and requires additional service time under that plan; or
- The participant has reached the eight (8) year term limit, but it is recommended by the CP, and DS to continue services.

Special considerations are reviewed by the program manager on a case-by-case basis. Requests must be made by the DS with supporting documentation from the family demonstrating the financial hardship and/or the CP demonstrating justification to continue services outside of the term limit.

Justification must include supporting therapeutic data directly related to goals identified on the care plan. The program manager or designee will review submitted requests within 15 calendar days. The DS will notify the family and/or the provider of the decision within five (5) business days of the determination. If approved, the written care plan and/or PA will be updated in the designated electronic system of record within five (5) business days of the decision.

2175 OVERPAYMENTS AND RECOVERY

If the DS finds a discrepancy between provider payments and the total plan type costs, they must complete an ATAP Reconciliation Request Form (ATAP-BF-03). The form must be submitted to their supervisor. See the job aid Over-Payment Reconciliation Request (ATAP-BF-JA-01) for details on how to complete the process.

The DS's supervisor is required to review the reconciliation request and all corresponding documents. If necessary, the reconciliation will be added to the Reconciliation Request Tracking Workbook tool found in the ATAP Teams channel by either the DS or the supervisor. Billing staff review the tracking tool against every invoice they process and must complete the reconciliation from the next payable invoice.

2176 RESERVED

2180 RESERVED

2190 RESERVED

2198 AUTHORITY

7 CFR 273.4(a)(6)(i)

NAC 427A

NRS 427A.875

NRS 432B.220

MEDICAID SERVICES MANUAL CHAPTER 2500

MEDICAID SERVICES MANUAL CHAPTER 3700

2199 ACRONYMS AND DEFINITIONS

Active Status - Status when the case will be assigned to a Developmental Specialist directly following the determination of eligibility. Participants in active status are eligible to receive ATAP funding.

Alternative and Augmentative Communication (AAC) - Describes different forms of communication that assist persons that are not able to use verbal speech to communicate.

Annual Review of Services (ARS) - Review of services participant received under active status following either insurance year or active status start date based on ATAP care plan type to determine compliance and ongoing eligibility.

Appeal - Administrative review to establish if termination is appropriate.

Applicant - The person intended to receive ATAP services, their assisted decision maker, or their legal guardian.

Applied Behavior Analysis (ABA) - Evidence-based therapeutic service directed to solve behavior problems by providing antecedent and/or consequences that change behavior. Applied behavior analysis owes no affiliation with a particular intervention, rather it is a scientific problem-solving approach aimed at producing socially significant behavior change and improving quality of life for individuals, families, and communities.

Applied Behavior Analysis Board - The State of Nevada licensure board for qualified ABA providers.

Assessment Report - Detailed report documenting findings from a completed assessment. Required for eligibility and ongoing services.

Assistant Licensed Behavior Analyst (aLBA) - Bachelor's-Level practitioner licensed to practice as a BCaBA in the State of Nevada.

ATAP Funded Plan - ATAP Service Plan funded solely by ATAP.

Authorized Representative (AR) - Legal guardian of participant receiving services or the assisted decision maker if participant is over 18 years of age.

Autism Treatment Evaluation Checklist (ATEC) - Assessment tool used to establish a baseline of deficits and support needs across multiple domains.

Autism Spectrum Disorder (ASD) - Autism Spectrum Disorder (ASD) and Autism are both general terms for a group of complex disorders of brain development. ASD is a spectrum disorder and includes Autism, PDD-NOS and Asperger's Syndrome. These disorders are characterized, in varying degrees, by difficulties in social interaction, verbal and nonverbal communication and repetitive behaviors.

Behavior Consultant - Registered Behavior Technician operating under a case supervisory role who has demonstrated ongoing education with academic course credits specific to becoming a BCaBA or BCBA.

Board Certified Behavioral Analyst (BCBA, BCBA-D) - Graduate-level certification in behavioral analysis and can be independent practitioners who provide behavior-analytic services. May supervise the work of BCaBAs and RBTs and other professionals who implement behavior-analytic interventions. BCBA-D specifies doctoral or postdoctoral training in behavior analysis.

Board Certified Assistant Behavior Analyst (BCaBA) - Undergraduate-level certification in behavior analysis. May provide behavior-analytic services under the supervision of a BCBA and may supervise the work of RBT's.

Community Providers - Service providers on a service agreement with ATAP within the community that provide specific therapeutic services outside of ADSD.

Detention Alternative for Autistic Youth Court (DAAY) - Alternative court geared toward helping children with an autism diagnosis resolve legal issue and provide access to treatment providers.

Direct Services - Based on care plan provided to the Developmental Specialist by the Provider, direct services are rendered by a Registered Behavior Technician to implement care plan goals and engage the person in activities related to various treatment domains.

Eligibility - Process for determining whether an individual meets specified criteria for a service.

Explanation of Benefits (EOB) - A statement sent by a health insurance company to enrolled individuals explaining what medical treatment(s) and/or service(s) were paid for on their behalf.

Financial Hardship - Event that monthly expenses exceed income.

Hard File - Paper version of the participant's case record that includes all required program documentation and signatures.

Household - For ATAP financial eligibility review, household is defined as all individuals living and supported in the household, including both adults and children.

Individual Education Plan (IEP) A written statement for each child with a disability that is developed, reviewed, and revised in accordance with the Individuals with Disabilities Education Act (IDEA) Part B section 1414(d)(1)(A).

Learning Materials - Applied Behavior Analysis (ABA) related materials to aid in specific targeted goals based on the approved care plan.

Licensed Behavior Analyst (LBA) - Doctorate-level BCBA practitioner licensed to practice in the State of Nevada.

Monthly Allotment - Total funding approved per month based on the care plan type.

Nevada Early Intervention Services (NEIS) The ADSD state comprehensive early intervention services provider

Non-Compliance - Failure to comply with program requirements which may result in probation or termination of services.

Occupational Therapist (OT) - Licensed Clinician who provides rehabilitative services to individuals with mental, physical, or developmental impairments.

Parent Hours - Hours met by running parent programs assigned by the BCBA/BCaBA/Consultant, and/or funding additional therapeutic services out of pocket.

Participant - An individual who has been found eligible for ATAP services.

Physical Therapist (PT) - Evidence-based specialists in evaluating and treating disorders of the human body primarily by physical means. ATAP does not provide funding support for PT.

Probation - Temporary service time where a recipient who has been found noncompliant is evaluated to determine if they can return to compliance; or if closure from services is necessary.

Program Manager - The Chief, Clinical Program Planner, Clinical Program or Health Program Manager, who has oversight responsibility over a program(s).

Provider - An agency, organization or individual who has met the provisions of certification through RFQ process to provide contracted services to people served; OR

a community-based service provider under contract to deliver services to ATAP Participants.

Quality Assurance (QA) - QA refers to the systematic process of ensuring services meet established standards and program requirements.

Quarterly Review of Services (QRS) - Periodic review of recipient's ABA services completed every three months based on annual review date.

Registered Behavior Technician (RBT) - A professional who practices ABA under the supervision of a BCBA or BCaBA. Primarily responsible for providing the direct one-on-one service with the child.

Service Agreement (SA) - The contract to provide services that specifically identifies the scope of services, fee schedule, deliverables, and requirements relevant to the contractor/agency relationship.

Service Coordination (SC) - Program DS case management consisting of assessment, planning, referral, linkage, and monitoring.

Speech and Language Therapist (SLP) - Licensed clinicians educated in the study of human communication, its development, and its disorders. SLPs assess speech, language, cognitive-communication, and oral/feeding/swallowing skills.

Targeted Case Management (TCM) - Services that assist an individual in gaining access to medical, social, educational, and other supportive services and must include the following components:

- Assessment of the eligible individual to determine service needs.
- Development of a person-centered Care Plan.
- Referral and related activities to help the individual obtain needed services.
- Monitoring and follow-up.

Workshop Month - This is the month immediately following the provider's assessment month where additional funding for BCBA supervision and RBT intervention hours are available to the participant to allow for development of the ABA treatment plan, rapport building, and additional intervention at the onset of ABA therapy.