Chapter 11-000 Home and Community-Based Waiver Services for Children with Autism Spectrum Disorder

11-001 INTRODUCTION: This chapter addresses services provided under the Home and Community-Based Waiver for Children with Autism Spectrum Disorder.

11.001.01 Scope and Authority: These regulations govern the administration of Nebraska's Home and Community-Based Waiver for Children with Autism Spectrum Disorder. These regulations are authorized by and implement the Autism Treatment Program Act (Neb. Rev. Stat. §§ 68-962 to 68-966). Implementation of these regulations is contingent upon federal approval of the waiver.

11-001.02 Definitions: For purposes of this Chapter, the following definitions apply:

Autism Spectrum Disorder means disorders listed for Pervasive Developmental Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, to include Autism, Asperger's Syndrome, Children's Disintegrative Disorder, Rett's Disorder, or PDD-NOS (Pervasive Development Disorder Not Otherwise Specified). It may be abbreviated as ASD.

Aversive Stimuli means a negative, unpleasant, or punishing incentive to modify behavior.

Case Management (may also be referred to as Services Coordination):

Centers for Medicare and Medicaid (CMS) means the federal funding and administrative agency responsible for Medicaid (including waivers), Medicare, and State Children's Health Insurance Program (SCHIP) programs.

Child means an individual age 17 or younger.

Client: See Participant.

Complaint means the formal expression of dissatisfaction by a participant with the provision of a waiver service or the performance of an entity in conducting other activities associated with the operation of a waiver.

Confidentiality means communication entrusted in private and/or information about a specific person (including applicants, participants, and potential or current providers) and his/her situation. Confidentiality prohibits unauthorized release of information to the general public. See 465 NAC 2-005.

Conflict of Interest means a situation in which a personal or commercial connection is, may be, or may be perceived to be present, which limits or prevents an objective or impartial decision or action.

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Consent means that a document has been signed by the participant's guardian or parent indicating preference for home and community-based services through the waiver.

Cost-Sharing means the required out-of-pocket premium payment that a parent must pay for the service provided by the waiver.

Criminal History/Background Investigation means a process that is undertaken to determine whether a person who would provide services has been convicted of a crime.

Department means the Nebraska Department of Health and Human Services (may also be referred to as DHHS).

DHHS: See Department.

Documentation means written, dated, and authenticated evidence.

Early Intensive Behavioral Intervention (EIBI) means a variety of therapies for young children with autism based on behavioral research and principles. EIBI is used to decrease problem behavior and to increase social, language, self-help, and cognitive skills.

Fair Hearing means the administrative procedure that affords individuals the statutory right and opportunity to contest adverse decisions regarding Medicaid eligibility or benefits to a participant when denied eligibility, when eligibility is terminated, or when denied a covered benefit or service.

Guardian means the legally-assigned caregiver of a minor child.

Habilitation means services that are provided in order to assist an individual to acquire a variety of skills, including self-help, socialization, and adaptive skills. Habilitation is aimed at raising the level of physical, mental, and social functioning of an individual.

In-home Services means services that are provided in the waiver participant's home.

Intermediate Care Facility for the Mentally Retarded (ICF/MR) means an institution licensed by DHHS that provides habilitation and health services for persons with mental retardation or related conditions.

Legally Responsible Individual means a person who has a legal obligation under the provisions of state law to care for another person. Legal responsibility is defined by State law, and generally includes the parents (natural or adoptive) of minor children, legally-assigned caregiver relatives of minor children, and sometimes spouses.

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Level of Care means the specification of the minimum limitations in functioning amount of assistance that an individual must require in order to receive services in an institutional setting under the State plan.

License means proof of official or legal permission to provide a service and issued or recognized by the Nebraska Department of Health and Human Services.

Mechanical Restraint means any device attached or adjacent to an individual's body that s/he cannot easily remove that restricts freedom of movement or normal access to his/her body.

Medicaid means the Nebraska Medical Assistance Program established to provide medical and other health-related services to aged, blind, or disabled persons, dependent children; and any other persons otherwise eligible who do not have sufficient income and resources to meet their medical needs.

Medicaid Agency means the Nebraska Department of Health and Human Services – the state agency with responsibility for administering the Nebraska Medical Assistance Program and managing Medicaid funding provided to the state.

Medicaid State Plan means the comprehensive written document, developed and amended by DHHS and approved by the federal Centers for Medicare and Medicaid Services, which describes the nature and scope of the medical assistance program and provides assurances that DHHS will administer the program in compliance with federal requirements.

Multidisciplinary Team (MDT) means a group coordinated by a Services Coordinator or school coordinator and composed of the participant and his/her family as appropriate, participant guardian, if applicable, treatment professionals, and education autism professionals.

Participant means a child who has been determined eligible for and chooses to receive waiver services authorized in a Service Plan. (may also be referred to as Client)

Personal Restraint means the application of physical force without the use of any device for the purposes of restraining the free movement of an individual's body.

Primary Caregiver means the person who resides with the participant and is available on a 24-hour per day basis to assume responsibility for the care and supervision of the participant. This person provides this service without pay. This may include a caregiver who is employed outside the home if s/he retains “on-call” responsibility while away from the participant. The primary caregiver is physically with and responsible for meeting the participant’s needs at least 8 hours in a routine 24-hour day. Compensation provided to a foster parent for care of a child is not considered as payment for the purpose of this definition.

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Prior Authorized means a process where payment is made to a provider when authorization to furnish the item or service is obtained in advance from DHHS.

Provider means an individual or agency authorized by the Nebraska Department of Health and Human Services to provide waiver services.

Provider Agreement means the contract between the Medicaid agency and a service provider under which the provider or organization agrees to furnish services to Medicaid beneficiaries in compliance with state and federal requirements.

Restraint means any physical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body.

Seclusion means the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.

Services Coordinator means the person who is responsible for coordinating the waiver participant's Service Plan and services received.

Services Coordination means a set of activities that are undertaken to ensure that the waiver participant receives appropriate and necessary services. Under a Home and Community Based Waiver, these activities include (but are not necessarily limited to) assessment of service needs, Service Plan development, referral to services, and monitoring activities.

Service Plan means a written document that specifies the waiver and other services furnished to meet the needs of and to assist a waiver participant to remain in the community. The plan describes the types of services to be furnished; the amount, frequency, and duration of each service; and the type of provider to furnish each service.

Slots means Nebraska's quota of waiver participants.

Time Out is a therapeutic procedure that involves either (1) removing an individual from an agitating situation in order to allow the individual to regaining self-control or (2) temporarily restricting access to positive reinforcers in accordance with an approved behavior management plan in order to reduce problem behavior.

Transition means the process of moving or assisting a participant leaving one waiver to another waiver or to community resources.

Waiver means Nebraska's Home and Community-Based Services (HCBS) Waiver for Children with Autism Spectrum Disorder.

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Waiver Staff means any person performing administrative duties related to the waiver.

Waiver Year means the 12-month period that begins on the date the waiver takes effect and the 12-month period following each subsequent anniversary date of the waiver.

11-001.03 Participant Rights and Responsibilities: Participants in this waiver and their guardians or parents have the following rights and responsibilities:

1. The right to apply for waiver services;
2. The right to have a decision made and, if eligible, services provided in a timely manner;
3. The right to receive equal protection under the law, not being subject to discrimination on the basis of race, color, national origin, sex, age, disability, religion, or political belief;
4. The right to have program requirements and service options explained in understandable, accessible, and culturally appropriate terms and the responsibility to ask questions;
5. The right and responsibility to participate in decision making in all aspects of supports and services;
6. The right and responsibility to participate to the greatest extent possible in the development, implementation, and continued delivery of the Service Plan;
7. The right and responsibility to choose from among qualified providers;
8. The right and responsibility to identify information to be shared with a provider;
9. The right to have personal information kept confidential;
10. The right to be treated with respect by all persons involved in the Children with Autism Spectrum Disorder waiver program;
11. The right and responsibility to schedule service delivery with the provider and to notify the provider of any changes to that schedule;
12. The right to receive services by the dates established in the Service Plan;
13. The right to receive services as reflected in the Service Plan;
14. The responsibility to notify the Services Coordinator when there are changes in health, living situation, and support system or when there is a change, concern, or dissatisfaction with a provider or a service;
15. The right to receive timely notice of an action to reduce or end services; and
16. The right to complain or appeal if it appears an error has been made or if the there is dissatisfaction with a decision.

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11-002 PARTICIPANT ELIGIBILITY CRITERIA: To be eligible for the waiver service, an individual must meet all of the following requirements:

1. Be a child and have a medical diagnosis of an Autism Spectrum Disorder or educational verification of autism;
2. Service initiated prior to the age of nine years;
3. Nebraska resident and living at home with a caregiver;
4. Meet the Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care criteria showing care needs equal to those of Medicaid-funded ICF/MR residents;
5. Be eligible for Medicaid through the Nebraska Medical Assistance Program;
6. Participate in an assessment with a Services Coordinator, resulting in an outcome-based, cost-effective Service Plan;
7. Have received an explanation of ICF/MR services and the waiver service and elected to receive the waiver service;
8. Demonstrate progress toward the attainment of treatment goals;
9. Participate in only one Nebraska Home and Community Based Services Waiver;
10. When applicable, the parent/guardian meets cost sharing obligations; and
11. Utilize an available waiver slot.

The Services Coordinator must determine each of the above are met before authorizing services.

11-002.01 Notice of Ineligibility: If the client does not meet eligibility criteria, the Services Coordinator must provide Form HHS-6, "Client Notice of Action" to the participant/legal representative. Notices to clients must contain:

1. A clear statement of the action to be taken;
2. A clear statement of the reason for the action;
3. A specific regulation citation which supports the action; and
4. A complete statement of the client's right to appeal.

11-003 ACCESS AND ELIGIBILTY: Children with Autism Spectrum Disorder and their families access the service through an application to the Department of Health and Human Services.

11-003.01 Application: The applicant must complete the application form (480-000-600) to apply for this waiver and send the application to DHHS for processing. The application must be signed by the applicant's parent/guardian and the date and time received documented by DHHS.

11-003.02 Statewide Availability: Waiver slots are allocated on a statewide basis.

11-003.03 Initial Application and Selection Process: The initial selection begins with all applications postmarked by a pre-announced deadline date being drawn randomly and numbered in the order they are drawn. Completed and signed applications will be processed for eligibility in the numbered order until the pre-determined slots are filled. Remaining applicants will be notified in writing that they have been placed on the waiting

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list. Applications postmarked after the deadline will be accepted and numbered in order of receipt and placed on the waiting list. The Services Coordinator must:

1. Accept applications of potential waiver participants and date and time stamp the application;
2. Validate the diagnosis/verification of Autism Spectrum and screen application for ICF/MR level of care;
3. Verify the client has active Medicaid or a pending Medicaid application. If application has not been made for Medicaid, the Services Coordinator must immediately refer client/legal representative to Medicaid intake.
4. Meet with the child and parent/guardian within fifteen working days after the validation of ASD and level of care screen to complete the assessment of services and supports, and finalize the ICF/MR level of care determination, provided that Medicaid status is open or pending.
5. Determine child's involvement in Early Intervention or special education;
6. Notify initial participants who have been selected in writing of this decision and inform the remaining applicants in writing that they have been placed on a statewide participant waiting list; and
7. Notify applicants who do not meet participant eligibility criteria of this decision by following the process outlined in 480 NAC 11-002.01.

11-003.04 Ongoing Application and Selection Process: For all completed and signed applications received following the initial application process, each application must be dated and time stamped in the order of receipt and added to the waiting list. As slots open, the process for applications to determine eligibility outlined in 11-003.03 must be followed.

11-003.05 Determination of Autism Spectrum Disorder: Autism Spectrum Disorder includes the disorders outlined in the DSM-IV TR for Pervasive Developmental Disorder: Autism Disorder, Asperger's Syndrome Disorder; Children's Disintegrative Disorder; Rett's Disorder; and Pervasive Development Disorder – Not Otherwise Specified.

Written documentation of Autism Spectrum Disorder, either through a medical diagnosis or educational verification, must be provided with the application and maintained in the applicant/participant file.

11-003.05A Medical Diagnosis: The medical diagnosis must be made by a qualified, licensed, or certified diagnostician.

11-003.05B Educational Verification: The verification must be conducted by a school district with assessments done by a multidisciplinary team as defined by the Nebraska Department of Education. The process is outlined in the Nebraska Department of Education Regulations and Standards for Special Education Programs, Rule 51. The verification may be a primary or secondary designation.

11-003.06 Age: The child must be under the age of nine or have received early intensive behavioral intervention services before the child's ninth birthday to be eligible for this waiver. This includes all services meeting the service definition in 480 NAC 11-005.01 that were provided prior to application for this waiver regardless of the payer.

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The Services Coordinator is required to verify that the prior services meet the scope and frequency of the waiver service.

11-003.07 Level of Care: The child must meet this Intermediate Care Facility for the Mentally Retarded (ICF/MR) criteria at the time of application and at each subsequent annual review:

1. The child has a diagnosis of mental retardation or a related condition (defined in 480 NAC 11-005.04A) which has been confirmed by prior diagnostic evaluations/standardized tests and sources independent of the ICF/MR; and
2. The child can benefit from "active treatment" (defined in 42 CFR 483.440(a) and 471 NAC 31-001.02). "Benefit from active treatment" means demonstrable progress in reducing barriers to less restrictive alternatives.

11-003.07A Related Condition: A severe, chronic disability that meets all of the following conditions:

1. It is attributable to:
   a. Cerebral palsy or epilepsy; or
   b. Any other condition, other than mental illness, (such as autism) found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons;
2. It is manifested before the person reaches age 22;
3. It is likely to continue indefinitely;
4. In the case of a child under three years of age, results in at least one developmental delay;
5. In the case of a person three years of age or older, results in substantial functional limitations in three or more of the following areas of major life activity:
   a. Self-care;
   b. Understanding and use of language;
   c. Learning;
   d. Mobility;
   e. Self-direction; or
   f. Capacity for independent living; and
6. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are life-long or of an extended duration and are individually planned and coordinated.

11-003.08 Medicaid Eligibility: The child must meet the eligibility requirements of the Nebraska Medical Assistance Program as outlined in 468 NAC, 469 NAC, or 477 NAC.

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11-003.09 Participant Financial Responsibility: Parents of children receiving this service who have the financial means must share in the cost of the service provided to their minor child. Children in foster care or subsidized adoption will be excluded. This will be done by a monthly premium set by a sliding fee scale and determined by DHHS based on the parent(s)' income and the income of the child(ren) receiving the service. See 468 NAC; 469 NAC; or 477 NAC; for timelines related to re-evaluation of income.

11-003.09A Premium Payment:

1. On-going premiums will be billed monthly and must be paid in order to be eligible for Medicaid;
2. Premiums can be paid up to three months in advance;
3. Premiums are due no later than the 21st day of the month before the month for which the payment is designated (for example, premium payment for June must be paid no later than the 21st day of May.)
4. Children will be terminated from autism waiver eligibility after failure to pay the premium for 60 days.

11-003.10 Waiver Eligibility Effective Date: The participant's waiver eligibility period may begin no earlier than the date of the parent/guardian's signature on the consent form and the date that Medicaid is effective. The consent form must be signed at initial determination only and remains valid as long as the waiver case is open. If the participant's guardianship changes, a new, signed consent must be obtained.

11-004 PLANNING FOR SERVICES

11-004.01 Participation in Assessment and Service Plan: The child's parent/guardian must be willing to participate in assessments of the child's needs and planning for the child's individualized service and treatment plan.

11-004.02 Service Plan: The Services Coordinator must, together with the parent/guardian, school, and treatment professionals, develop the Service Plan based upon assessment results. The Service Plan includes the autism treatment plan. Copies of the Service Plan are distributed to other persons and agencies at the direction of the participant's parent/guardian. The Service Plan must be completed within fourteen calendar days of completing the assessment.

(Exception: If a participant age three and under receives Services Coordination through the Early Development Network, the Individualized Family Service Plan (IFSP) developed for that program meets the Service Plan requirement for this waiver. The IFSP document must specify the needed service to be authorized through this waiver with a clear distinction between services funded through Education and services funded by Medicaid. A copy of the IFSP is maintained in the waiver case record.)

11-004.03 Health and Welfare of Participant: The Service Plan must ensure the participant's health and welfare, including consideration of acceptable risk with manageable back-up plans. If the participant's health or welfare is in jeopardy, the service cannot be provided.

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11-004.03A Use of Restrictive Interventions for Behavior Management: The use of restrictive interventions as defined in 480 NAC 11-005.04 must be prior approved by the participant's parent or guardian and included in the Service Plan.

11-004.04 Freedom of Choice: A participant may select any willing and qualified provider.

11-004.05 Cost: The Services Coordinator must determine the cost of the Service Plan for the participant and determine that the estimated total monthly cost does not exceed the waiver annual cost limit approved by CMS. This must be done before the Consent is signed. Services included in calculating the cost of the Service Plan are the Medicaid non-waiver services of home health services (excluding therapies), private duty nursing, personal assistance service, medical transportation and all ongoing waiver services.

11-004.06 Consent for Waiver Services: The Services Coordinator must provide an explanation of services in an ICF/MR and the service in this waiver to the parent/guardian and the parent/guardian must then give consent for the child's participation in the waiver by signing the consent form (480-000-602).

The form is signed at initial determination only, and remains valid as long as the waiver case is open. If the participant's guardianship changes, a new, signed consent must be obtained. The participant's waiver eligibility period may begin no earlier than the date of the parent/guardian's signature on the consent form.

11-004.07 Coordination of Services with Education: Participants receiving the waiver service may also be involved in a special education program with the school. Waiver services cannot duplicate or replace services available through the school.

11-004.07A Services Coordination Role: The Services Coordinator must involve the school personnel in developing the Service Plan.

11-004.08 Authorization of Services: The service under this waiver must be prior authorized by DHHS based on the Service Plan, and may be authorized for up to a 12-month period. The service must not be authorized until the participant's Medicaid eligibility has been determined and the waiver consent form has been signed.

When the service has been authorized, a written description of the authorized service must be given to the provider. This must include, at a minimum, the amount and frequency of service provision, specific service components authorized, and authorized rate. A copy of the authorization must be provided to the provider and the participant's parent/guardian with a copy maintained in the participant's case file.

11-004.09 Monitoring: Monitoring activities must be performed on an ongoing basis to continually evaluate the effectiveness of the Service Plan and to ensure quality service delivery.

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The Supervising Behavior Therapist will provide monthly progress notes to the Services Coordinator. The Services Coordinator will contact the parent/guardian to discuss the progress of all elements of the service plan.

11-004.09A Role of the Services Coordinator: The Service Coordinator must:

1. Contact the participant, at a minimum, bi-monthly by telephone or other communication, and conduct in-person visits at least once every six months. All in-person contacts must be at a time, date, and location convenient to the participant/parent/guardian. (Exception: An unannounced visit may occur as part of provider monitoring.);
2. Ensure, by both participant and parent/guardian interview and observation, that the Service Plan continues to meet the participant's and family's needs and necessary referrals are being made;
3. Review service usage and cost and revise the Service Plan as needed;
4. Maintain regular communication with Medicaid eligibility staff to monitor ongoing Medicaid eligibility; and
5. Whenever information is received that the care needs of a participant has changed, the Services Coordinator must determine whether a reassessment of the participant's level of care is necessary.

11-004.09B Reassessment of Level of Care: If a reassessment is needed during the course of the waiver year, the Services Coordinator must begin the reassessment process within two working days of receipt of the information.

If no reassessment has been needed during the course of the waiver year, the Services Coordinator must review the participant's continued ICF/MR Level of Care eligibility at least every 12 months and completed prior to the end date of the previous eligibility period. Results must be documented by updating the Level of Care form and Service Plan. The Services Coordinator must also review the consent document to assure that the parent/guardian signature is current.

If a reassessment determines that the participant does not continue to meet the ICF/MR Level of Care, a Notice of Action (480-000-604) must be sent to the parent/guardian and the case closed.

11-004.10 Transition Planning: Six months before completion of the EIBI services, the Services Coordinator, school coordinator, the participant's family, and others chosen by the family must meet to develop a transition plan for the participant. If a participant needs ongoing supportive services, the parent/guardian may choose to be referred to other programs and services.

11-004.11 Services Coordination Documentation: Services Coordination documentation must be maintained for each participant, retained for six years, and may consist of either paper and/or computer data. Documentation must include:

1. Initial referral information;
2. Waiver eligibility and authorization;
3. ICF/MR level of care;

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4. Assessments and other functional documentation;
5. Original Service Plan and updates; and
6. All written notices to, and other communication with, the parent/guardian.

11-005 SERVICE PROVIDED - Early Intensive Behavioral Intervention: Early Intensive Behavior Intervention (EIBI) is the Medicaid habilitation service available to children eligible for this home and community-based waiver program.

11-005.01 Service Description: EIBI is a variety of therapies for young children with autism to assist them in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. It is based on behavioral research and principles and used to decrease problem behavior and to increase social, language, self-help, and cognitive skills.

A Supervising Behavioral Therapist directs and supervises a team including Lead Therapists and Applied Behavior Analysis Technicians, who provide the therapy as outlined in the participant's treatment plan. The treatment plan is included in the waiver Service Plan. Each challenging behavior to be reduced and skill to be increased by the therapy is precisely defined with measurements before and during treatment to assess whether the treatment is working or whether it needs to be changed. Methods based on behavioral research are used to identify effective ways to motivate and teach the child. Functional assessments are used to identify events that trigger and reinforce challenging behavior.

Parents or primary caregivers are trained on how to use EIBI procedures as part of the child's waiver service.

11-005.02 Provision of Service: Providers must provide individualized services based on behavioral research and principles applicable to the specific needs and strengths of the participant as determined by the participant's treatment team. The individualized treatment goals must result in demonstrated progress toward the goals. The waiver service must be provided statewide to eligible participants for whom a slot is available.

11-005.03 Place of Service: This service will be primarily provided in the participant's residence but may also be in a clinical setting and/or other natural environment for the participant to assure a smooth therapeutic transition between environments.

11-005.04 Provider Use of Restraints and Restrictive Intervention: The use of personal restraints and restrictive interventions by a waiver service provider must be prior approved by the parent or guardian in consultation with DHHS and included in the Service Plan signed by the parent/guardian.

11-005.04B Use of Personal Restraints and Restrictive Interventions: Positive approaches in addressing behaviors with less restrictive methods must be attempted first and regularly applied until determined to be ineffective and documented in writing before the use of more restrictive measures. Methods

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must not be employed as punishment for the convenience of staff, a substitute for habilitation, or be reactive in design. Restrictive interventions must be

implemented in a manner designed to protect the participant's safety, dignity, well-being, and civil and human rights. A record must be kept on each use of a personal restraint and restrictive intervention with a participant.

11-005.04B1 Allowable Interventions: The use of personal restraints, time-outs, and seclusionary time-outs as defined in this section will be allowable methods of behavior management.

Methods used must address behaviors that:

1. Are obstacles to becoming more independent;
2. Interfere with the ability to take part in habilitation; or
3. May lead to self-injury or a threat to the safety of others.

11-005.04B1a Personal Restraint: The use of a personal restraint involves a staff member holding an individual in a forceful manner that restricts the movement of an individual's arms, legs, head, or other body parts. This does not include:

1. Briefly holding an individual without undue force to help calm or comfort the individual,
2. Holding the individual's hand to safely escort the individual from one location to another, or
3. Briefly physically guiding the individual's hands when used as a prompting or teaching strategy.

11-005.04B1b Time-Out: Time-out is a therapeutic procedure that involves either:

1. Removing an individual from an agitating situation in order to allow the individual to regain self-control; or
2. Temporarily restricting access to positive reinforcers in accordance with an approved behavior management plan in order to reduce problem behavior.

11-005.04B1c Seclusionary Time-Out: Seclusionary time-out is a therapeutic procedure that involves temporarily restricting access to positive reinforcers in order to reduce problem behavior by placing the individual in a time-out room or crib for a time-limited period (e.g., 2 minutes) while under the constant observation and supervision of a trained adult and in accordance with an approved behavior management plan. Seclusionary time-out is only used when less restrictive forms of time-out have been tried and been ineffective.

11-005.05 Prohibited Interventions: The use of medicine, mechanical restraints, aversive stimuli, corporal punishment, abuse (verbal, physical, psychological, sexual)

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denial of an adequate diet, or a child in services disciplining another child served are not allowable habilitation techniques under the waiver and are therefore prohibited.

11-005.05A Use of Medications: The use of any medication as a chemical restraint by a waiver service provider to control behavior or to restrict a child's freedom of movement is not allowable. Medications that are prescribed as a standard treatment for a child's medical or psychiatric condition are not considered restraints.

11-005.06 Review Committee: The Supervising Behavior Therapist will utilize a review committee to provide prior review and approval of all policies and participant plans that include the use of restrictive procedures for the purpose of ensuring that participant rights are not violated. A current list of committee members and minutes of each meeting must be maintained.

The Review Committee must include persons qualified to evaluate behavior management research studies/proposals and the technical adequacy of proposed behavior management interventions.

11-005.07 Limitations: Medicaid does not cover EIBI:

1. When the participant is in the hospital or other institution;
2. As a convenience for the family or caregiver in place of a child care or respite care provider;
3. When it duplicates other Medicaid State Plan services or other services available to the participant at no cost; or
4. At any time the participant does not qualify for Medicaid or does not meet eligibility guidelines.

11-005.08 Maximum Length of Service: The maximum length of service allowable is 36 consecutive months. The participant must receive at least one unit of service each month to maintain enrollment in the waiver. The only exception to this would be in the event of temporary hospitalization of the participant or in the event of a temporary family disruption that prevents service provision.

11-005.08A Exception Process: The parent/guardian may request an exception to the Services Coordinator and provide documentation of the circumstances. The Services Coordinator will make a decision and it must be documented in the participant's file.

11-005.09 Early Intensive Behavioral Intervention Rates: Rates are established by the Division of Medicaid & Long-Term Care. (480-000-681).

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11-006 PROVIDER ENROLLMENT AND GENERAL STANDARDS

11-006.01 Resource Development: Resource Development is the process of recruiting, approving, and monitoring service providers to assure clients have a choice of providers. DHHS staff assigned this function are responsible for the following fundamental processes for providers: recruitment; approval and annual reviews; monitoring; billing instruction and record keeping. Resource Developers are also responsible for reviewing, investigating, and taking appropriate action on any complaints received about the provider.

11-006.02 Provider Approval/Renewal Process: Before approval at both the initial approval and annual renewal of provider agreements, the following must be completed by staff with Resource Development responsibilities for all providers of service:

1. Conduct an in-person interview which includes an on-site evaluation if the service is provided in the provider's setting;
2. Review and complete the Service Provider Agreement (480-000-630) and Provider Checklist (480-000-631) with the provider. Service provider agreements are effective up to 12 months, are never back-dated, and must be agreed upon and signed by all parties on or before the effective date of the agreement.
3. Determine that all general and service-specific provider standards are met.
4. Follow the identified process related to central register and criminal history checks outlined in 480 NAC 11-006.04 and 11-006.05.
5. Obtain a completed and signed IRS Form W-9 and place it in the file.

11-006.02A Service Agreement Revision: Providers must report/request changes to existing service agreements. An address change which does not affect the service location or a change in services provided may be changed manually and initialed by staff with Resource Development responsibilities on the original agreement.

A change in provider name, Federal Tax Number (FTN), or Social Security number requires a new agreement and signature. For services provided outside of the client's home, if the location changes, a new agreement, and service specific checklist, must be completed.

11-006.03 Provider General Standards: All home and community-based services (HCBS) waiver providers are Medicaid providers (see 471 NAC 2-000) and must meet the following general provider standards:

1. Follow all applicable Nebraska Department of Health and Human Services regulations (Nebraska Administrative Code Titles 465, 471, and 480).
2. Bill only for services which are authorized and actually provided.
3. Submit billing documents after service according to provider agreement.
4. Accept payment as payment in full and assure that the rate charged does not exceed the amount charged to private payers.

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5. Not provide services if s/he is the legally responsible relative (that is, spouse of participant or parent of minor child who is a participant).
6. Not discriminate against any employee, applicant for employment, or program participant or applicant because of race, age, color, religion, sex, handicap, or national origin, in accordance with 45 CFR Parts 80, 84, 90; and 41 CFR Part 60.
7. Retain financial and statistical records for six years from date of service provision to support and document all claims.
8. Allow federal, state, or local offices responsible for program administration or audit to review service records, in accordance with 45 CFR 74.20 – 74.24; and 42 CFR 431.107. Inspections, reviews, and audits may be conducted on site.
9. Keep current any state or local license/certification required for service provision.
10. Provide services as an independent contractor, if the provider is an individual, recognizing that s/he is not an employee of the Department or of the State.
11. Agree and assure that any false claims (including claims submitted electronically), statement, documents, or concealment of material fact may be prosecuted under applicable state or federal laws (42 CFR 455.18).
12. Respect every participant's right to confidentiality and safeguard confidential information.
13. Understand and accept responsibility for the participant's safety and property.
14. Not transfer the provider agreement to any other entity or person.
15. Operate a drug free workplace.
16. Not use any federal funds received to influence agency or congressional staff.
17. Not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom s/he provides services. This may include a substantiated listing as a perpetrator on the child and/or adult central registries of abuse and neglect, and/or the sex offender registries.
18. Allow for DHHS Adult Protective Services Central Registry, the DHHS Child Central Register of Abuse and Neglect, the Nebraska Sex Offender website, and the License Information System checks on him/herself, family member if appropriate, or if an agency, agree to allow Department of Health and Human Services staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place.
19. Have the knowledge, experience, skills, and/or abilities necessary to perform the task(s) authorized.
20. Report changes to appropriate DHHS or Operating Agency staff, for example, no longer able/willing to provide service, changes in participant function.
21. Agree and assure that any suspected abuse or neglect will be reported to law enforcement and/or appropriate DHHS staff.

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11-006.04 Individual Providers: Prior to approval at both the initial approval and annual review, staff with Resource Development responsibilities must do the following:

1. Obtain a completed Self-Disclosure/Felony/Misdemeanor Statement from the provider applicant (480-000-632). If service is to be provided in the provider's home all household members age 19 or older must also complete the Self-Disclosure Felony/Misdemeanor Statement;
2. Perform a criminal background check of the provider applicant prior to provider approval. If service is to be provided in the provider's home, a criminal background check must be performed on all household members age 19 or older;
3. Check the name of the provider applicant against the DHHS Adult Protective Services Central Registry, the DHHS Child Central Register of Abuse and Neglect, the Nebraska Sex Offender Registry, and the License Information System. If service is to be provided in the provider's home, all household members age 19 or older must also have their names checked.

11-006.05 Clinic/Agency/Facility Providers: Prior to approval at both the initial approval and annual review, staff with Resource Development responsibilities must do the following:

1. Review evidence that the clinic's/agency's/facility's employees have completed a Self-Disclosure/Felony/Misdemeanor Statements from the provider applicant (480-000-632). Employees must complete this statement annually.
2. Review evidence that criminal background checks have been completed on the clinic/agency/facility employees.
3. Review evidence that the clinic's/agency's/facility's employees have been cleared against the DHHS Adult Protective Services Central Registry, the DHHS Child Central Register of Abuse and Neglect, the Nebraska Sex Offender Website, and the License Information System.
4. Review the clinic's/agency/facility's policy that ensures criminal background, registry, and website checks are completed on each employee. Review the policy of the clinic/agency/facility to determine that safeguards are in place to protect the well-being of waiver clients. This policy must assure that no staff person identified through this process poses a danger to the health and safety of any client. If assurances are not in place, the provider agreement must not be approved or any existing waiver provider agreement must be terminated.

11-006.06 Specific Criminal History: Staff with Resource Development responsibilities must deny or terminate service provider approval immediately when conviction has occurred in the following areas:

1. Child pornography;
2. Child or adult abuse;
3. Driving Under the Influence: Two or more within the last five years;
4. Domestic violence;
5. Shoplifting after age 19 within the last three years;
6. Felony fraud within the last 10 years;
7. Misdemeanor fraud within the last five years;
8. Termination of provider status for cause from any DHHS program within the last 10 years;

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9. Possession of any controlled substance within the last five years;
10. Possession of a controlled substance with intent to deliver within the last 10 years;
11. Felony or misdemeanor assault without a weapon in the last 10 years;
12. Felony or misdemeanor assault with a weapon in the last 15 years;
13. Prostitution or solicitation of prostitution within the last five years;
14. Felony or misdemeanor robbery or burglary within the last 10 years;
15. Rape or sexual assault; or
16. Homicide.

If other pending charges or convictions are found or charges listed above are pending, the situation must be reviewed to determine whether the participant's safety is in jeopardy and reasons for approval/non-approval documented.

11-006.07 Abuse/Neglect Registry: Before initial approval as a provider and at the annual renewal, a check of the DHHS Adult Protective Services Central Registry, the DHHS Child Central Register of Abuse and Neglect, the Nebraska Sex Offenders Website, and the License Information System must be done on all individual providers.

11-006.07A Reason for Denial/Termination: A service provider's approval must be denied/terminated immediately if a registry/website report on the provider as perpetrator is shown as substantiated.

If a protective services investigation is in progress, the situation must be reviewed to determine if the participant's safety is in jeopardy. If so, the provider's approval must be denied/terminated immediately.

11-006.08 Disclosure of Information by Providers: Staff with Resource Development responsibilities must assure that providers disclose the following information as required under 42 CFR 455, Subpart B. See 471 NAC 2-006.

1. Ownership and control;
2. Business transactions; and
3. The providers' owners and other persons convicted of crimes against Medicare, Medicaid, or Title XX (Social Services Block Grant) programs.

11-006.08A Excluded Providers: Staff with Resource Development responsibilities must assure that providers do not appear on US Department of Health & Human Services Office of Inspector General's List of Excluded Individuals/Entities.

11-006.09 Previous Termination of Provider: A provider's approval must be denied/terminated if information is received that termination of provider status has occurred for cause from any DHHS program within the last ten years.

11-006.10 Agency as a Provider: If an agency as a provider plans to subcontract with another organization or individual providers to provide a portion of service delivery, the agency provider must provide the following information to DHHS:

1. Name of subcontractor; and

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2. Federal identification number, Social Security number, and any licensure information (for example, RN license number).

The agency provider is responsible for the performance and actions of its subcontractor(s) and the subcontractor(s) must comply with these regulations.

11-006.11 Provider Related to Participant: A legally responsible relative, for example, the parent of a child age 18 or younger who is a waiver participant, cannot be approved specifically as a provider for his/her child who is a Medicaid waiver participant.

Other family members who meet the provider qualifications may be a provider with these exceptions: a stepparent of the Medicaid waiver participant, a foster parent of the Medicaid waiver participant, and any other legally responsible guardian of the Medicaid waiver participant.

Should there be any question as to whether a paid provider falls in any of the categories listed, the Services Coordinator must request a determination. DHHS legal counsel will make the determination.

11-006.12 Provider Denial/Termination: If the provider does not meet all of the provider standards for the service to be provided, the following must be completed:

1. Document the reason for the denial/termination;
2. Provide written notice to the provider which includes:
   a. Explanation of the reasons for the denial/termination;
   b. Citation of the regulations on which the denial/termination was based; and
   c. Notification of the provider's right to appeal the decision/action.

11-006.13 Voluntary Withdrawal: A written notice to the potential provider is not required if s/he voluntarily withdraws before approval.

11-006.14 Terminating a Provider Agreement: Either DHHS or the provider may terminate an agreement by giving at least 30 days advance written notice. The 30-day requirement may be waived for the provider in the case of emergencies such as illness, death, injury, fire, or other natural disaster. If the provider violates any of the provisions of the Service Provider Agreement, then the Agreement may be terminated immediately. If there are any damages arising from the violation, DHHS may pursue legal remedies to recover the damages. Any money due to the provider which accrued before the violation may be offset against the damages.

When an agreement is terminated , the steps in 480 NAC 11-006.12 must be followed.

11-006.15 Provider Appeals: All Medicaid providers have the right to appeal any decision/action that has a direct adverse effect on the provider (471 NAC 2-003). Appealable actions include but are not limited to a determination that a provider standard is not met or disallowance of a claim. Providers may not appeal service authorization terminations related to a participant's eligibility or choice of provider.

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A provider must request a hearing in writing within 90 days of the date that the provider notification letter is postmarked. The provider must appeal the state's request for refunds within 30 days of the date the provider notification letter is mailed. To request a hearing, the provider must submit a written request to the DHHS Director of the Division of Medicaid & Long-Term Care, identifying:

1. The basis of the appeal;
2. The participant(s) involved, if applicable; and
3. The name of the Services Coordinator.

11-006.16 Individual Provider Record Keeping: Providers of waiver services must retain the following documentation for six years:

1. Documentation which supports provision of services to each participant served under the waiver, including but not limited to, services plans and reports; service authorizations, and billing records; and
2. Service Provider Agreement.

11-006.17 DHHS Documentation: DHHS must maintain documentation on each provider for six years. Documentation must include:

1. Provider agreements ;
2. Verification of Central Registry and criminal background checks;
3. Self-Disclosure Felony/Misdemeanor Statements;
4. Written notices to, and other communication with, the provider;
5. Activities related to services delivery monitoring;
6. Narrative documentation (for example, waiver staff decisions and actions; and other factual, relevant information); and
7. Billing and payment records.

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11-007 PROVIDER TYPES, QUALIFICATIONS, AND POLICIES

11.007.01 Provider Type Qualifications: In addition to the general provider standards outlined in 480 NAC-11.006, autism waiver providers must meet specific qualifications based on the provider type. Three provider types are included as providers in this waiver:

1. Supervising Behavior Therapist
2. Lead Therapist
3. Applied Behavior Analyst Technician

Providers may enroll as only one provider type.

11.007.02 Supervising Behavior Therapist: This provider must have:

1. Earned a Doctoral or master's degree (Ed.D., Ph.D., Psy.D ; M.A., M.S., M.S.W.) in Behavior Analysis, Education, , Occupational/Physical Therapy, Psychology Rehabilitation Therapy, Speech Pathology/Speech Therapy, or Social Work; and

2. Completed 9 months of supervised practicum experience in which the primary duties were:
   (a) Designing, implementing and monitoring programs for individuals with autism spectrum disorders, and/or,
   (b) Overseeing the implementation of programs for individuals with autism spectrum disorders by others. Supervised experience includes face-to-face meetings for at least two hours every two weeks with a qualified service provider; and
3. Completed at least 60 hours of direct experience working with children with Autism Spectrum Disorder. Demonstration that the experience criteria are met by one of the following:
   (a) Documentation as an active Board Certified Behavior Analyst (BCBA) by the National Behavior Analyst Certification Board, OR
   (b) Documentation as a Fellow of the Association for Behavior Analysis, OR
   (c) Graduate school transcripts and training certificates reflecting the following coursework of at least 225 classroom hours of graduate-level instruction in the following areas:
      (1) Ethical considerations – 15 hours;
      (2) Definition & characteristics and principles, processes & concepts of empirically- based service provision for individuals with autism spectrum disorders - 45 hours;
      (3) Behavioral assessment of autism spectrum disorders and selecting intervention, outcomes and strategies - 35 hours;
      (4) Empirical (data-based) evaluation of interventions - 20 hours;
      (5) Measurement of behavior and displaying & interpreting behavioral data - 20 hours;
      (6) Behavioral change procedures and systems support 45 hours;
      (7) Discretionary (additional courses in relevant areas such as autism, human development, mental disorders, or developmental disabilities) – 45 hours.

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11.007.03 Lead Therapist: This provider must have:

1. Documentation of being a Board Certified Behavior Analyst (BCBA) by the National Behavior Analyst Certification Board; or
2. Completed at least 60 hours of supervised experience working with children with Autism Spectrum Disorder and been trained to mastery criterion in implementing behavioral interventions and earned a baccalaureate degree in one of the following:
   (a) Behavior Analysis;
   (b) Education;
   (c) Occupational or Physical Therapy;
   (d) Psychology Rehabilitation Therapy;
   (e) Speech Pathology/Speech Therapy; or
   (f) Social Work.

11.007.04 Applied Behavior Analysis Technician: This provider must have:

1. Completed college coursework or program instruction in Applied Behavior Analysis; and
2. Been trained to mastery criterion in implementing behavioral interventions.

11-007.05 Provider Policies and Procedures: The provider must have written policies and procedures on management of inappropriate participant behaviors. These policies and procedures must specify and define approved intervention methods in compliance with these regulations and include a description of the mechanism for monitoring the use of the intervention. These policies must be in writing and include the following:

1. Prohibit use of mechanical restraints, aversive stimuli, abuse (physical, verbal, psychological, sexual), corporal punishment, denial of an adequate diet, and a child in services disciplining another child served;
2. Specify and define intervention procedures that are approved to be utilized;
3. Specify that less restrictive methods must be attempted and regularly applied and determined to be ineffective before the use of more restrictive measures and how that will be documented along with reasons for the use of more restrictive measures are necessary;
4. Specify staff training requirements;
5. Specify that methods to manage inappropriate behavior must be used only in a manner that protects the safety, well being, and civil and human rights of the participant;
6. Provide that these policies and procedures must be communicated to and available to all staff, participants, family, and/or guardians;
7. Define and specify procedures governing use of restrictive or intrusive measures such as personal restraints, time out procedures, and emergency use of restrictive measures; and

8. Specify that each plan utilizing personal restraint or restrictive intervention procedures must be reviewed and approved before implementation by the participant's treatment team, the parent or participant's legal guardian, and the agency's review committee.

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11-007.05A Provider Training: All providers must be trained on the use of restraints and restrictive interventions before providing the waiver service.

11-008 CONFLICT OF INTEREST: This section identifies areas of possible conflict of interest:

11-008.01 Applicant/Participant Related to Waiver Staff: A waiver staff person performing services coordination activities must not provide services coordination activities for an applicant/participant to whom s/he is related or has a personal relationship which might affect the assessment or plan.

11-008.02 Provider Related to Waiver Staff: A waiver staff person must not approve, re-approve, evaluate, or negotiate provider agreements with providers to whom s/he is related.

11-008.03 Staff as Legal Representative: No employee of DHHS or entity contracted to conduct waiver administrative duties may serve as guardian, conservator, power of attorney, or protective payee of a waiver participant for whom s/he:

1. Determines eligibility;
2. Authorizes services or assistance;
3. Provides direct service; and/or
4. Has any other professional relationship which may be considered a conflict of interest.

11-008.04 Waiver Staff as Board Members: If any waiver staff serves on a Board of Directors or a standing committee of a community organization that votes on issues, s/he must abstain from any decision making or voting on issues related to this waiver.

11-009 ADVERSE DECISIONS ON PARTICIPANT ELIGIBILITY

11-009.01 Participant Notification: Persons who request, apply for, or receive services may request a hearing on any adverse action or inaction. These may include, but are not limited to, a potential waiver participant being denied services, a waiver participant's services being reduced, or a waiver participant being determined ineligible for continued waiver services. The Services Coordinator must send written notice of denial, reduction, or termination of services to the participant and parent/guardian. The notice used is Form HHS-6. The notice must contain:

1. A clear statement of the action to be taken;
2. A clear statement of the reason for the action;
3. A specific regulation citation that supports the action;
4. A complete statement of the participant/guardian's right to request a hearing; and
5. A clear statement that if a hearing is requested within ten days following the date the notice of finding is mailed, the adverse action will not be carried out until a fair hearing decision is rendered.

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Notice of reduction or termination of services must be mailed at least ten calendar days before the effective date of action. Exception: If the termination of waiver services is because of loss of Medicaid eligibility, the effective date of the termination must match the effective date of the termination of Medicaid eligibility.

If the adverse action is to deny acceptance of a waiver referral, the Services Coordinator must send the notice to the applicant as soon as the decision is made.

11-009.01A Reasons for Denial/Termination: The Services Coordinator must provide a notice of denying or terminating waiver eligibility in these circumstances:

1. The unavailability of a waiver slot;
2. The participant has no waiver service need;
3. The participant's needs are being met by another source;
4. The parent /guardian has not supplied needed information to complete the eligibility process;
5. The participant fails to meet the specified eligibility criteria;
6. A Service Plan cannot be developed/maintained which protects the participant's health and welfare;
7. The parent/guardian has not signed necessary forms consenting to waiver services; or
8. The participant moves out of Nebraska.

11-009.01B Advance Notice Not Required: The Services Coordinator must provide a Notice of Action (480-000-604) to close a case, but advance notice is not required in the following circumstances. However, the notice must be provided no later than the date of the closure.

1. The death of a participant;
2. The Services Coordinator receives a clear written statement signed by a parent/guardian that the participant no longer wishes services;
3. The participant has been admitted to an ICF/MR or hospital on a long-term basis;
4. The participant's whereabouts are unknown;
5. The Services Coordinator establishes the fact that the participant has been accepted for Medicaid services by another state; or
6. An authorization period is ending and the participant's parent/guardian has not acted upon a request for a level of care and plan of services and supports review.

11-009.01C Advance Notice in Cases of Probable Fraud: At least five days advance written notice must be given if the Services Coordinator has facts indicating that action should be taken to discontinue, suspend, terminate, or reduce assistance because of probable fraud by the participant; and the facts have been verified where possible through collateral sources.

11-009.01D Provider Notice: When a participant's services are being changed or terminated, the Services Coordinator must provide written notice to the

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provider of the change in service provision or termination of payment for waiver services.

11-009.02 Participant Appeals of Adverse Actions: The Department of Health and Human Services must provide opportunities for fair hearings as defined in 42 CFR 431, Subpart E, to participants or their legal representatives who are not given the choice of home and community-based services as an alternative to ICF/MR services or who are denied the services of their choice (see 465 NAC 2-001.02 and 465 NAC 6-000).

A participant's parent/guardian has the right to appeal the following Services Coordination decisions/actions:

1. Failure to act upon a request within the mandated time period;
2. Failure to offer the choice between Home and Community-Based Waiver Services and ICF/MR services;
3. Denial of eligibility;
4. Denial, termination, or reduction of services; or
5. Termination of the waiver case.

11-009.03 Continuation of Services: If the participant submits a request for a fair hearing in accordance with the timeframe prescribed in fair hearing policy, the adverse action must not take place until the hearing decision is rendered. If services have already been terminated, they must be reinstated until the hearing decision.

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