MoHealth Net

PERSONAL CARE MANUAL

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Introduction

The Missouri Title XIX (Medicaid) Personal Care Program offers medically-related services designed to meet the maintenance needs of participants with a chronic, stable condition. Available services include: basic and advanced personal care, personal care assistance consumer-directed services, and authorized nurse visits. Personal Care Assistance Consumer-Directed service requirements can be found in **Section 2.8** of this manual.

The purpose of the authorized nurse visit is to provide increased supervision to the personal care aide, intensified health care assessment of the participant, and in some cases, certain nursing services that do not meet the requirements for reimbursement under either the Medicare or MO HealthNet Home Health Programs. The authorized nurse visit is used for advanced personal care plan development, on-the-job training for the advanced personal care aide, and monthly evaluation of advanced personal care participants.

Section 1—Reimbursement Methodology

1.1 The Basis for Establishing a Rate of Payment

The MO HealthNet Division (MHD) is charged with establishing and administering the rate of payment for those medical services covered by the Missouri Title XIX Program. MHD establishes a rate of payment that meets the following goals:

- Ensures access to quality medical care for all participants by encouraging a sufficient number of providers
- Allows for no adverse impact on private-pay patients
- Assures a reasonable rate to protect the interests of the taxpayers
- Provides incentives that encourage efficiency on the part of medical providers

Funds used to reimburse providers for services rendered to eligible participants are received in part from federal funds and supplemented by state funds to cover the costs. The amount of funding by the federal government is based on a percentage of the allowable expenditures. The percentage varies from program to program and in some cases different percentages for some services within the same program may apply. Funding from the federal government may be as little as 60% or as much as 90%, depending on the service and/or program. The balance of the allowable, 10-40%, is paid from state General Revenue appropriated funds.

Under a fee schedule each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable fee established. MHD determines a maximum allowable fee for the services based upon all applicable information and current appropriated funds:

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- Recommendations from the State Medical Consultant and/or the provider subcommittee of the Medical Advisory Committee and/or stakeholders
- Medicare's allowable reasonable and customary charge payment or cost-related payment, if applicable
- Charge information obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public. Implicit in the use of charges as the basis for fees is the objective that charges for services be related to the cost of providing the services.

Total expenditures for MO HealthNet must be within the appropriation limits established by the General Assembly. If the expenditures do not stay within the appropriation limits set by the General Assembly and funds are insufficient to pay the full amount, then the payment for services may be reduced pro rata in proportion to the deficiency.

1.2 Personal Care Service

Reimbursement for personal care services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the state agency to be a reasonable fee, consistent with efficiency, economy and quality of care. Payment for covered services is the lower of the provider's actual billed usual and customary charge or the maximum allowable per unit of service.

1.3 Fee Schedule

The **Fee Schedule** identifies covered and non-covered procedure codes, restrictions, allowed units and the MHD allowable fee per unit. The Fee Schedule is updated quarterly and is intended as a reference not a guarantee for payment.

The **Fee Schedule** allows for the downloading of individual files or the search for a specific fee schedule. Some procedure codes may be billed by multiple provider types. Categories within the Fee Schedule are set up by the service rendered and are not necessarily provider specific.

Section 2-Benefits and Limitations

2.1 General Program Information

Service Definition

Personal care services are medically-oriented tasks provided in the individual's home that are approved by the State or reviewed and approved as certified by a physician as the home care necessary to meet a participant's physical needs. This enables the participant to remain in their home and be treated on an outpatient basis rather than in a hospital or nursing facility. The requirement of physician's approval versus physician's certification is dependent upon which participant group (e.g., elderly, children, etc.) for whom the personal care services are being authorized. For purposes of the Personal Care Program, the term "home" includes participants

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residing in Residential Care Facilities (RCFs) or Assisted Living Facilities (ALFs). These services must be reasonable and necessary for the treatment of a medical condition and must maintain or increase the functional capacity of the participant. Personal care services are intended to meet personal, physical requirements, as opposed to general housekeeping requirements, and to meet needs that cannot be met by other resources. Personal care services covered by the Missouri Title XIX (Medicaid) Program must be provided by a qualified individual who is not a member of the participant's family.

NOTE: For the purposes of the Personal Care Program, a family member is defined as a spouse; parent; sibling; child by blood, adoption, or marriage (step-child); grandparent; or grandchild.

Personal Care Tasks

Examples of personal care service tasks that may be performed are:

- Planning, preparation and clean-up of meals
- Making beds and changing sheets with the participant in or out of the bed, as required
- Brushing, combing and shampooing hair
- Bathing/showering, including bed baths
- Brushing teeth and cleaning dentures when the participant is unable
- Cleaning and cutting fingernails and toenails of participants without contraindicating conditions
- Shaving with an electric or safety razor, as appropriate an electric razor must be used for the participant with diabetes or contraindicating conditions
- Giving assistance to and from the bed to a wheelchair, walker or chair when a participant is weight bearing
- Assisting the participant with ordinarily self-administered medications (open bottles, get water)
- Shopping for groceries or household items specifically required for the health and maintenance of the participant
- Applying non-prescription topical ointments/lotions to unbroken skin at the participant's direction

The encouragement and instruction of participants in self-care may be a component of any other task(s) as described above; however, encouragement and instruction do not constitute a task in and of themselves.

Advanced personal care services provide assistance with activities of daily living (ADLs) when such assistance requires devices and procedures related to altered body functions. These services are described in greater detail later in **Section 2.7**.

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Personal Care Service Limitations

Per the personal care service definition above, personal care services are covered only in the participant's home. These services are not covered in a hospital or nursing facility. The only acceptable place of service code to use when filing claims is 12 (Home).

Personal care providers are not reimbursed for the following activities:

- Providing therapeutic/health-related activities that should be performed by a Registered Nurse (RN), Licensed Practical Nurse (LPN) or home health aide under Title XVIII or Title XIX Home Health Programs
- Providing transportation
- Accompanying the participant outside of the home
- Administering patent or prescribed medications
- Cleaning or cutting fingernails or toenails of a participant with diabetes or medically-contraindicating conditions (i.e., participants taking anticoagulant medication, those diagnosed with a peripheral vascular disease or have a compromised immune system), unless this service is performed by a nurse during an authorized nurse visit
- Cleaning the floor and furniture in areas not occupied by the participant. For example, cleaning the entire living area if the participant occupies only one small room.
- Cleaning spaces shared by members of the entire household
- When the task is such that members of a household may reasonably be expected to share or do for each another, unless the task is above and beyond typical activities that would be provided for a household member without a disability
- Laundry, other than that incidental to the care of the participant. For example, laundering clothing and bedding for the entire household, as opposed to simple laundering of the participant's bed smock or gown.
- Shopping for groceries or household items other than items required specifically for the health and maintenance of the participant. This does not preclude a personal care aide shopping for items needed by the participant, but also used by the rest of the household.
- Providing personal care services to a participant by a member of the participant's family
- Performing or furnishing out-of-state personal care services

Provider Participation Requirements

Providers of personal care service, must have a valid MO HealthNet Personal Care Provider Agreement in effect with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance Unit (MMAC).

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To enroll as a provider of personal care services, the applicant must be one of the following:

- An approved DSS, MMAC Title XX Social Services Block Grant (SSBG)/General Revenue (GR) provider. Providers must maintain their approval to participate as an SSBG/GR provider, whether or not they actually service SSBG/GR eligible participants.
- A RCF or ALF, licensed by the Department of Health and Senior Services (DHSS), Division of Regulation and Licensure. RCF/ALF personal care providers may only furnish personal care services to participants in their RCF/ALF. RCF/ALF personal care providers must maintain their RCF/ALF license.

To enroll with MMAC to provide personal care services, providers should send an email to **MMAC.IHSContracts@dss.mo.gov**. Refer to the **MMAC HCBS webpage** for more information.

Electronic Visit Verification

In accordance with the 21st Century CURES Act and **13 CSR 70-3.320**, providers are required to utilize an electronic visit verification (EVV) system to document services rendered related to the delivery of in-home services for all Medicaid-funded agency and consumer-directed (CDS) personal care services. EVV requirements do not apply to services provided in residential or group settings, such as RCFs or ALFs. The EVV system must collect the following data elements: type of service performed, individual receiving the service, date of the service, location of the service delivery when it begins and ends, individual providing the service, and time the service begins and ends; and the system must have the ability to exchange data with the EVV Aggregator Solution (EAS). It is the responsibility of each provider to register their contracted EVV vendor, log onto the EAS at least weekly to verify the vendor sends timely and accurate visit data to the EAS, and report any suspected falsification of data to MMAC. Agencies with no data in the EAS for participants that have received Medicaid-funded in-home personal care services are out of compliance with EVV requirements. All EVV data must be available for inspection by the Departments of Social Services and Health and Senior Services. Providers found to be out of compliance with EVV requirements will be subject to administrative actions by MMAC. Refer to the **Electronic Visit Verification webpage** for more information, such as administrative rules and other announcements.

Participant Eligibility Requirements

To be eligible for personal care services, participants must:

- Have current eligibility for MO HealthNet benefits. Participants who are eligible for MO HealthNet coverage on a spend down basis may be authorized to receive personal care services during periods when they meet their spend down liability. A participant is responsible for the cost of services received during periods of time when they have not met their spend down liability. Refer to the **General Sections Manual** for more information regarding spend down.
- Be assessed by DHSS or its designee (reference **Section 3** in this manual) to meet nursing facility level of care due to having certain impairments and unmet needs, such that the

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participant would require admission to a hospital or a long-term care facility if personal care services were not provided

- Be willing to receive comprehensive assessment from DHSS or its designee
- Be reassessed annually by DHSS or a provider re-assessor to facilitate determination of continued eligibility for HCBS and the amount of assistance authorized. Refer to **Section 2.18** of this manual for further information regarding provider reassessor requirements.
- Have unmet needs that can be safely met at a cost that does not exceed the average monthly MO HealthNet cost of nursing facility care

The participant must be eligible for MO HealthNet services on the day the service is delivered, or the provider will not be reimbursed through MO HealthNet. This is a requirement even when the service has been prior authorized. It is the responsibility of the provider to verify the participant's MO HealthNet eligibility on the day the service is provided via **eMOMED** or by using the Interactive Voice Response (IVR) system at (573) 751-2896.

Authorization of Personal Care Services

All units of Title XIX personal care services must be authorized by DHSS or its designee before services can be delivered.

The detailed plan of care or authorization for services shows how many units of service are authorized and specifies the period of time covered by the authorization. In addition, the plan of care includes a list that shows the specific service activities that must be performed, at a minimum, by the personal care attendant. Additional service activities may be performed as long as the time spent does not exceed the units authorized.

The authorization for services is based on participant needs identified during the initial assessment and reassessment processes. The needs of the participant must be reassessed at least annually, and the amount of assistance authorized will be maintained, adjusted or eliminated accordingly.

More information about documentation requirements is contained in **Section 3** of this manual.

Coordination of Personal Care with Division of Developmental Disabilities

The Missouri Department of Mental Health (DMH), Division of Developmental Disabilities (DD), operates four (4) Home and Community-Based (HCBS) 1915(c) waivers for individuals with developmental disabilities. All four (4) waivers include personal assistance, including the option for self or family-directed waiver personal assistance.

The Centers for Medicare & Medicaid Services (CMS) does not allow waiver services to duplicate or supplant services covered by MO HealthNet, and requires that when a service is available under MO HealthNet, the waiver may provide services beyond the scope of the state plan.

Participants of any DD HCBS waiver who are also eligible for MO HealthNet personal care may also receive waiver personal assistance in these situations:

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- MO HealthNet limits on number of units for personal care are reached and more assistance with ADLs and/or instrumental activities of daily living (IADLs) is needed
- Person requires personal assistance at locations outside of their residence
- The individual has behavioral or medical needs and they require a more highly-trained personal assistant than is available under MO HealthNet
- When the individual or family is directing waiver personal assistant services through a DD Fiscal Management Services contractor

When participants receive both State Plan personal assistance and DMH-DD HCBS waiver personal assistance services, the DHSS service authorization system must coordinate closely with the local DD support coordinator.

2.2 Administrative Requirements

Personnel—General Administrative Requirements

Providers must meet the following general administrative requirements for personnel:

- Document all staff qualifications in personnel records, such as verification of RN or LPN license, certified nurse assistant (CNA) certification, which should include at least the license or certification number, post-secondary degree if required, or any required experience.
- Establish, implement and enforce a policy governing communicable diseases that prohibits provider staff contact with participants when the employee has a communicable condition, including colds or flu. Ensure that reporting requirements governing communicable diseases, including hepatitis and tuberculosis, as set by DHSS (**19 CSR 20-20.020**), are carried out.
- Establish a grievance system through which a participant may present grievances concerning the operation of the personal care program. The provider must document the participant's receipt of information regarding the grievance procedures.
- Protect DSS and DHSS, their employees, agents and/or representatives from any and all liability, loss, damage, cost and expense which may accrue or be sustained by DSS and DHSS, its officers, agents or employees as a result of claims, demands, costs, suits or judgments against it arising from the loss, injury, destruction or damage, either to person or property, sustained in connection with the performance of the personal care program.
- Establish, enforce and implement a policy whereby all contents of the personnel files of its employees are made available to DSS and DHSS employees or representatives when requested as part of an official investigation of abuse, neglect, financial exploitation, misappropriation of participant's funds or property or falsification of documentation which verifies service delivery.

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- Maintain bonding and personal and property liability insurance coverage on all employees and volunteers who are involved in delivering personal care services.
- Ensure that all employees are registered with DHSS **Family Care Safety Registry** (FCSR). The provider shall then request background information on all employees and abide by the rules set forth in **19 CSR 30-82.060** regarding any employees not eligible for employment.
- Conduct a criminal background screening as required in **RSMo 192.2495**.
- Check the DHSS Employee Disqualification List (EDL) or the FCSR, prior to employment for prospective employees, to assure their names do not appear on the list. Providers may call the DHSS Interactive Voice Response (IVR) system at (573) 522-6510 or access it on the **DHSS EDL website**. These automated systems will allow verification of the EDL status of applicants for employment, or current employees, and provide a confirmation number verifying that the required EDL check was performed. The systems are available for calls and website visits seven (7) days a week, 22 hours per day. System maintenance occurs between 2:00 a.m. and 4:00 a.m., each day.
- If it is found that a prospective employee is on the EDL, then that individual must not be considered further for employment.
- If using the **FCSR** to conduct the EDL and criminal background screenings, providers must meet the statutory background screening requirements, provided there is sufficient documentation showing the identity of the person who was screened, the dates the screening was required and completed, and the outcome of the screening. Providers are encouraged to check each employee monthly against the **Office of Inspector General's List of Excluded Individuals/Entities (LEIE)** for current employees and prior to employment for prospective employees. All employee background screenings must be retained by the provider either electronically or in paper form and must be made available upon request by DSS/MMAC or DHSS staff.
- Issue to each personal care aide, at time of employment, a permanent identification card that shows the provider's name and the aide's name and title. The provider shall require each personal care aide to carry the identification (ID) card to present to participants as necessary. The provider shall make every effort to repossess the ID card upon termination of employment. If unable to do so, the provider must retain on file a statement describing what efforts were made to recover the ID card.

Provider Service Delivery Standards

The following service delivery standards must be met by providers:

- Must have the capability to provide service outside of regular business hours, on weekends and on holidays to provide services in accordance with the plan of care for each participant. Service must be provided by qualified persons on the provider's staff.

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- Shall accept participants on the basis of a reasonable expectation that the participant's maintenance care needs can be met adequately by the provider in the participant's place of residence. Services must follow the plan of care.
- Prior to the delivery of service, the personal care aide shall receive a copy of the plan of care for the participant and be provided with information about the participant in order to appropriately deliver services to meet the needs of the participant.
- Must deliver the personal care services within 10 calendar days of receipt of the service authorization notification or on the beginning date specified by the authorization, whichever is later, and on a regular basis thereafter in accordance with the plan of care. If service is not initiated within the required time period, a detailed written justification must be maintained in the participant's file. Providers are encouraged to upload the justification into the participant's electronic case record.
- Must comply with the applicable statutes and regulations regarding reports of abuse or neglect. Must report all instances of potential abuse, neglect and/or exploitation of a participant to the appropriate state agency, including all instances that may involve an employee of the provider.

Participant's Rights and Procedures

The provider shall have a written statement of the participant's rights to be given to each participant and primary caregiver, when appropriate, at the time service is initiated, which includes, at a minimum, the right to:

- Be treated with respect and dignity
- Have all personal and medical information kept confidential
- Have direction over the services provided, to the degree possible, within the plan of care authorized
- Know the provider's established grievance procedure, how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution
- Receive services without regard to race, creed, color, age, sex, or national origin
- Receive a copy of the code of ethics under which services are provided

Discharge Policies and Procedures

Services for a participant shall be discontinued by a provider under the following circumstances:

- When the participant's case is closed by DHSS or its designee
- When the provider learns of circumstances that require the closure of a case for reasons including, but not limited to death, admission to a nursing facility or the participant no

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longer needs services. In these circumstances, the provider shall notify DHSS or its designee, in writing, and request that the participant's services be discontinued.

- When the participant is noncompliant with the agreed-upon plan of care. Noncompliance requires persistent actions by the participant, or their family/representative which negate the services provided in the plan of care. After all alternatives have been explored and exhausted, the provider shall notify DHSS or its designee, in writing, and request that the participant's services be discontinued.
- When the participant or participant's family threatens and/or abuses the personal care aide and/or provider to the point where the staff's welfare is in jeopardy and corrective action has failed. The provider shall notify DHSS or its designee, in writing, and request that the participant's services be discontinued.
- When a provider is unable to continue to meet the maintenance needs of a participant because the plan of care hours needed to ensure the health and safety of the participant exceed availability. In these circumstances, the provider shall notify DHSS or its designee, in writing, and request that the participant's services be discontinued.

When a provider is unable to continue to meet the maintenance needs of a participant or when a participant is noncompliant with the agreed-upon plan of care, the provider shall provide written notice of discharge to the participant or participant's family and DHSS or its designee, at least 21 days prior to the date of discharge. During this 21-day period, DHSS or its designee shall assist in making appropriate arrangements with the participant for transfer to another provider, institutional placement, or other appropriate care. Regardless of circumstances, the personal care provider must continue to provide care in accordance with the plan of care for these 21 days or until alternate arrangements can be made by DHSS, or its designee, whichever comes first.

Discontinuing services for a participant still in need of assistance shall occur only after appropriate conferences with DHSS or its designee, participant and the participant's family.

Provider Compliance

Providers must have a valid MO HealthNet Personal Care Provider Agreement in effect with MMAC to provide personal care services, pursuant to federal and state laws and regulations. MMAC may suspend or terminate the written agreement of any provider found to be out of compliance with the written agreement and with the provisions and/or requirements of applicable state laws and regulations.

Providers must notify the MMAC Provider Enrollment Unit at least 30 days before a change of ownership or control of the provider's business. The provider must notify MMAC within at least 90 days before any other changes, such as change in location, telephone number, administrative, or corporate status. The provider must notify MMAC by completing the **Home and Community Based Services Change Request** form. The request and supporting documentation should be faxed to (573) 634-3105.

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MMAC conducts both program and fiscal monitoring of the Personal Care Program. On-site monitoring visits may be announced or unannounced. The providers must agree to comply with any reviews conducted by MMAC and provide necessary information to conduct state and/or federal audits. MMAC may, in accordance with the protective service mandate (RSMo Chapter 192), take action to protect participants from providers who are found to be out of compliance with statutory and regulatory requirements applicable to the Personal Care Program, when such noncompliance is determined by MMAC to create a risk of injury or harm to participants.

2.3 Personnel Requirements

Administrative Supervisor Qualifications

A personal care administrative supervisor shall be designated by the provider ownership or administrative management to supervise the day to day delivery of direct personal care services. This position of responsibility may be assigned in conjunction with other duties within the provider organization.

The designated administrative supervisor shall be at least 21 years of age. In addition, the supervisor must meet at least one (1) of the following criteria before performing the supervisory duties required by these standards. The supervisor must:

- Be a RN currently licensed in Missouri
- Have a baccalaureate degree
- Be a LPN, currently licensed in Missouri with at least one (1) year of experience with the care of the elderly, or individuals with disabilities or medically-complex conditions
- Have at least two (2) years of experience in the care of the elderly, or individuals with disabilities or medically-complex conditions

If the designated administrative supervisor is not a RN, the provider agency must have a designated RN currently licensed in Missouri on staff or employed as a consultant available to fulfill the specific functions described later in this section.

Administrative Supervisor Duties

The duties of the designated administrative supervisor include, at a minimum, the following:

- Read a copy of the MO HealthNet Program requirements contained in Section 2 of this provider manual. All nursing staff (RNs, LPNs and Graduate Nurses (GNs)) and administrative supervisors must have documentation in their personnel files that they have been given and have read this section.
- Establish, implement and enforce a policy governing communicable diseases that prohibits provider staff contact with participants when the employee has a communicable condition, including colds or flu. Assure that reporting requirements governing communicable

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diseases, including hepatitis and tuberculosis, as set by DHSS regulation **19 CSR 20-20.020**, are carried out.

- Monitor the provision of personal care services and authorized nurse visits to assure that services are delivered in accordance with the personal care plan. This shall be primarily in the form of an at least monthly review and comparison of the aides' records of provided services with the personal care plan. The units of service authorized, the tasks specified, and the authorized frequency of delivery must be compared to the units, tasks and frequency of delivered services. The monitoring reports shall be available for review by DSS and DHSS upon request. Documentation, including the reason, must be kept on authorized services and units not delivered.
- Make an on-site visit at least annually to evaluate each personal care aide's performance and the adequacy of the plan of care, including review of the plan of care with the participant. The personal care aide may or may not be present for this evaluation. A written record of the evaluation shall be maintained in the personnel file of the personal care aide. This record must contain, at a minimum, the participant's name and address, the date and time of the visit, personal care aide's name, observations related to the participant's receipt of plan of care delivery, the participant's satisfaction of the personal care aide's performance and the adequacy of the plan of care, and must be signed and dated by the supervisor who prepared it and by the personal care aide. If the required evaluation is not performed or not documented, the personal care aide's qualifications to provide the service may be presumed inadequate and all payments made for services by that personal care aide may be recouped.
- Approve, in advance, all changes to the plan of care based on supervisory on-site visits, information from the personal care aide, or observation by the RN, or a combination of these, as noted and dated in the participant's file.
- Make appropriate recommendations to DHSS or its designee, including proposed increase, reduction or termination of services, or need for increased DHSS involvement based on supervisory on-site visits, review of reports, information from the personal care aide, observation by the RN, or a combination of these.
- Assist in orientation and personal care training for personal care aides.
- Designate a trainer(s) to perform on-the-job training sessions required as part of the basic training of the personal care aide. (Refer to **Section 2.4**) The designated trainer(s) may be the personal care supervisor or a personal care aide who has been employed by a personal care provider at least half-time for a period of six (6) months.
- Communicate with the DHSS or its designee, regarding changes in any participant's condition and recommended changes in scope or frequency of service delivery. The provider must document in the participant file such communication.
- Be available for regular case conferences with DHSS or its designee.

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In-Home Agency Personal Care Aide Requirements

All basic personal care aides employed by the provider must:

- Be at least 18 years of age
- Be able to read, write and follow directions
- Not be the family member of the participant for whom personal care is to be provided, as defined in Section 2.1 of this manual

Nurse Supervision Requirements

RN supervision of personal care services is a requirement of the MO HealthNet Personal Care Program. Each MO HealthNet Personal Care provider must have a RN available to perform specific supervisory functions. While some of the nursing supervision functions may be delegated to a licensed practical nurse, as described in this section, the provider is still responsible for having registered nurse staff available to perform specified supervisory tasks. Depending upon the size and administrative structure of the provider, the registered nurse may also be the designated administrative supervisor.

If the provider's designated administrative supervisor is not a RN, the staff RN or the RN consultant shall initial and review all on-site visit reports made by the designated administrative supervisor.

If supervised by a RN, a LPN or GN may perform the RN supervisory activities described in this section.

2.4 Training

All personal care aides, whether basic or advanced personal care aides, who provide services reimbursed by MHD must meet or have met the basic training and in-service training standards set forth in this section. Advanced personal care aides have additional training requirements, discussed under Advanced Personal Care in Section 2.7 of this manual. The cost of all training is part of the provider's administrative cost and is not separately billable.

Documentation of Basic and In-Service Training

The provider shall have written plans for basic and in-service training of the personal care aide. These plans should include content for sessions. The plans should be updated as needed, to reflect the training needs of the provider's personal care aides, as well as, to incorporate any changes in the standards for Title XIX services.

The provider must maintain a report of each individual personal care aide's training in that aide's personnel record. The report must document the dates of all training, trainer's name, topics, number of hours and location, the date of first participant contact and the aide's signature. Participant contact may be either supervised on-the-job training or unsupervised service delivery. If a waiver of basic training has been granted, the personal care aide's individual training report shall contain supportive data for the waiver.

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Other required documentation includes a topical outline of each session's content, the mode of training (classroom or on-the-job), and the signature of the attendee(s). Deviations in content from the written plan should be noted and explained.

The documentation referenced in the above paragraph may be maintained in a master training log or may be filed in each personal care aide's personnel file. The documentation must be readily available for monitoring or inspection by DSS and DHSS.

When calculating training hours, a training hour is equal to 60 minutes.

Basic Training

When individuals are newly-employed as personal care aides, they shall receive a minimum of 12 hours of basic orientation training. The following requirements apply to this training:

- All basic training must be completed within 30 days of the first date of employment
- A minimum of six (6) hours of training must be completed prior to first participant contact
- At least two (2) hours of basic training must include orientation to the provider and the provider's protocols for handling emergencies
- Reading materials shall constitute no more than two (2) of the total 12 hours

Code of Ethics

As part of basic training, the provider shall distribute to all personal care aides a code of ethics. The code of ethics shall forbid, at a minimum, the following actions:

- Using the participant's car
- Consuming the participant's food or drink (except water)
- Using the participant's telephone for personal calls
- Discussing own or others' personal problems or religious or political beliefs with the participant
- Accepting gifts or tips
- Bringing other persons to the participant's home
- Consuming alcoholic beverages, or using medicine or drugs for any purpose, other than medical, in the participant's home or prior to service delivery
- Smoking in the participant's home
- Soliciting or accepting money or goods for personal gain from the participant
- Breaching the participant's privacy and confidentiality of information and records
- Purchasing any item from the participant even at fair market value

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- Assuming control of the financial and/or personal affairs of the participant or of their estate including power of attorney, conservatorship or guardianship
- Taking anything from the participant or from the participant's home
- Committing any act of abuse, neglect or exploitation

Training Contents

Basic training for all personal care aides shall include at least the following:

- Organization, purpose and philosophy of the personal care provider
- Relationship of the provider to the appropriate state agency, or its designee, and MHD
- Code of ethics
- Activities which shall and shall not be performed under the standards for personal care services
- Basic first aid and procedures to be followed in an emergency
- Information about record-keeping and report forms
- Techniques in basic personal care activities
- Techniques in food preparation, nutritional requirements and basic sanitation practices
- Household management and home maintenance skills, as they relate to personal care
- Safety precautions and recognition of job hazards
- Information about the availability of other community resources
- Occupational Safety Hazards Act (OSHA) standards regarding precautions to be taken to avoid risks associated with bloodborne pathogens
- Review of infection control and universal precaution procedures as defined by the Centers for Disease Control and Prevention (CDC)

Waiver of Basic Training

Experience or Aide Certification

The provider may waive four (4) hours of the required training with adequate documentation in the employee's records that the aide received similar training during the previous 12 months, with the exception of the statutorily-required dementia training. The six (6) hours of training prior to participant contact must include two (2) hours of provider agency orientation.

Licensed Nurse/Certified Nurse Assistant

All hours of basic training, with the exception of the two (2)-hour provider agency orientation and the statutorily-required dementia training, may be waived, with adequate documentation in the

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aide's personnel record that the aide is a RN, LPN or certified nurse assistant. The documentation shall include the employee's license or certification number, which must be current and in good standing at the time the training was waived.

Provider Verification

It is ultimately the provider's responsibility to judge whether or not the previous training was sufficient to justify a waiver. If the training is waived, the provider should obtain adequate documentation about the employee's previous training. The provider may obtain written or phone verification of the previous training which includes at least the following:

- The name, address, and phone number of the employer from whom the training was received
- The date or dates of the training
- A summary of the content and number of hours of the training
- For phone verification, the date of the phone contact and the name of the person verifying the training information

Supervised On-The-Job Training Review

The on-the-job training review shall consist of the observation of the aide's performance of hands-on personal care tasks under the direction of a designated trainer. The designated trainer(s) may be the RN, LPN, GN, supervisor or an experienced aide who has been employed by the provider agency at least six (6) months. This review may take place during an on-site visit to a participant or in a classroom demonstration and must be performed within 30 days of the first date of employment.

The supervised on-the-job training review should include observed demonstration of personal care tasks such as:

- Making beds and changing sheets with the participant in the bed
- Brushing, combing and shampooing hair
- Giving bed baths and assisting with other baths
- Giving assistance to and from the bed to a wheelchair, walker or chair when a participant is weight bearing
- Cleaning and cutting fingernails and toenails of participants without contraindicating conditions
- Applying non-prescription topical ointments/lotions to unbroken skin at the participant's direction

The designated trainer must document that the aide can successfully perform demonstrated tasks. This documentation must be filed in the aide's personnel record.

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In-Service Training

All personal care aides shall receive a total of five (5) hours of in-service training annually after the first 12 months of employment.

The provider may waive the required annual five (5) hours of in-service training, and require only two (2) hours of refresher training annually, when the aide has been employed for three (3) years and has completed 15 hours of in-service training that meets the standards set forth in this section. In-service training curricula shall include updates on Alzheimer's disease and related dementia. This waiver shall be adequately documented and noted in the personal care aide's records.

Training should be conducted by the provider staff, as well as, by professionals available from other agencies such as the University Extension Service, County Health Departments, Red Cross or other community resources. Training shall reinforce and extend the content of basic training. Training should include topics such as:

- Processes and effects of aging
- Problem identification and procedures for making appropriate referrals
- Non-medical personal care of the incapacitated participant
- Techniques for assisting the participant with impaired mobility
- Meal preparation for special diets
- Home management and budgeting
- Comparison shopping techniques
- Problems common to the elderly and individuals with disabilities
- Recognizing and reporting abuse or neglect
- Acquired Immunodeficiency Syndrome (AIDS) education
- Alzheimer's and related dementia
- Death and dying

2.5 Records

The personal care provider shall document implementation of requirements for the following, as applicable:

- Coordination with other providers
- Non-discrimination on the basis of disabilities
- Administrative policies and procedures

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Participant Case Record

The provider shall maintain a participant case record including records of service provision for each participant. The participant record is confidential and shall be protected from damage, theft and unauthorized inspection. It shall be maintained in a central location, and shall contain at least the following:

- The person-centered care plan authorization from the participant's electronic case record, which documents authorization for all units of service provided
- Documentation of undelivered services
- For RCFs and ALFs, the personal care aide's name, participant's name, dates of service delivery and activities performed on each date. All paid units of service must be documented. Reference **13 CSR 70-91.010(4)(A)2.A-F** for additional documentation requirements. If these documents are not maintained in the participant's case record, they must be maintained in an area that is readily-available for monitoring or inspection by DSS and DHSS.
- Documentation of all correspondence and contacts with the participant's physician or other care providers
- Any other pertinent documentation regarding the participant
- Documentation that prior to initiation of service the participant was informed of their rights under the Advanced Health Care Directive. Documentation should include whether an advanced health care directive was executed by the participant.

Personnel Record

The provider must maintain an individual record for each personal care aide. A personnel record is a confidential record and shall be protected from damage, theft and/or unauthorized inspection. An individual personnel record shall include, at a minimum, the following:

- Employment application with the personal care aide's signature showing education and work experience
- The aide's date of birth, date of employment and the date the provider terminated the aide (if applicable)
- For supervisory staff, documentation that they have been provided with and have read **Section 2.3** of this manual
- Documentation of basic and in-service training received (individual training report; reference **Section 2.4** of this manual)
- Documentation of any waiver or reduction of employment or training requirements (reference **Section 2.4** of this manual)

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- Annual performance evaluation which includes observations from at least one on-site visit (reference **Section 2.3** of this manual)
- Signed statement(s) verifying that the personal care aide received a copy of the participant's rights and the code of ethics, and that the provider's policy regarding confidentiality of participant information was explained prior to service delivery
- Statement identifying the personal care aide's position, including whether the employee performs administrative duties for the provider or delivers services to participants
- Returned ID card for a terminated personal care aide, or documentation of why it is not available

The provider must also maintain the written plans for basic and in-service training (**Section 2.4** of this manual), and the supervisor's and the RN's on-site visiting log (**Section 2.3** of this manual).

Retention of Records

MO HealthNet providers must retain, for a minimum of six (6) years from the date of service, fiscal and medical records that coincide with and fully document services billed to MHD, and must furnish or make the records available for inspection or audit by DSS and DHSS, or their representatives, upon request. Refer to the **General Sections Manual** for further information on retention of records requirements.

Adequate Documentation

All services provided must be adequately documented in the medical record. **13 CSR 70-3.030, Section (2)(A)** defines adequate documentation and adequate medical records as follows:

- Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.
- Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered.

The provider shall not submit claims solely on the basis of the prior authorization, but must base claims upon documentation of actual services rendered. The participant may have been in the hospital or nursing facility during a month, may have been away from the home visiting family or friends, or there may have been other reasons why all services which were prior authorized were not necessary or could not be delivered. The prior authorization merely establishes the maximum number of units and types of services which may be given to a participant during a time period. All units billed to MO HealthNet must be supported by the documentation of delivery as described in this section.

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Required Documentation

HCBS in-home agency personal assistant providers must have an EVV system in place. Refer to **Section 2.1** of this manual and the **Electronic Visit Verification webpage** for additional information regarding EVV for in-home agency services.

RCF/ALF personal assistant providers are not required to use EVV; however, they must document the following:

- The date of service
- The time spent providing the service, documented by one (1) of the following methods:
    - Actual clock time of the start and actual clock time of the end of any period of uninterrupted one-on-one service to a single individual. For example, if a personal care aide is providing services to one (1) individual and devotes undivided attention to the care required by that individual, the actual clock time the aide began the services is the start time, and the actual clock time the aide finished the care is the end time. (For example: 9:30 a.m. to 10:30 a.m.)
    - When the personal care aide divides their time among a number of individuals, all tasks performed for each participant by date of service and by staff shifts during each 24-hour period must be documented.
    - Any other method that includes all required elements of documentation listed in this section
- A description of the service (specific tasks)
- The name of the personal care aide who provided the service
- The participant's name and MO HealthNet number

The provider shall not submit claims solely on the basis of the prior authorization, but must base claims upon documentation of actual services rendered. The participant may have been in the hospital or nursing facility during a month, may have been away from the home visiting family or friends or there may have been other reasons why all services which were prior authorized were not necessary or could not be delivered. The prior authorization merely establishes the maximum number of units and types of services which may be given to a participant during a time period. All units billed to MHD must be supported by the documentation of delivery as described in this section.

DHSS assumes a 31-day month in calculating the monthly maximum number of personal care units for which each participant is eligible. However, several plans of care assign tasks to be performed seven (7) times per week (daily); and, several months in the year contain fewer than 31 days. For RCF and ALF personal care providers, when a participant's plan of care includes at least one (1) task that is to be performed daily, then the participant's monthly maximum allotment cannot be reached in a month containing fewer than 31 days. When determining compliance with this limitation, the

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following steps may be used by RCF and ALF personal care providers to manually calculate the monthly authorization:

- Step 1 - Identify the daily tasks (tasks shown on the plan of care as daily or with a frequency of seven (7) times a week)
- Step 2 - Identify the total number of minutes for these daily tasks in a week (this may appear directly on the plan of care, or determined by multiplying the total number of daily task minutes by seven (7)
- Step 3 - Divide the number in step 2 by 15. Round up to the nearest whole number (.5 or more rounds up). This will equal the daily task units per week.
- Step 4 - Divide the number in step 3 by 7. Round up to the nearest whole number (.5 or more rounds up). This will equal the daily task units per day.
- Step 5 - Multiply the number in step 4 by the number of days fewer than 31 in the month. (Take the number from step 4 and multiply it by 1 for April, June, September and November. Multiply it by 3 for February. Multiply it by 2 for February in a leap year.)
- Step 6 - Take the total from step 5 and subtract it from the total number of authorized units. This will equal the new total of authorized units for the shorter month.

Accrued Units

A unit of personal care service is 15 minutes of direct service to the participant, including time spent completing work vouchers and obtaining participant signatures.

Personal care providers may bill up to one (1) full month of service on one (1) detail line of a claim. It is permissible to accrue partial units of less than 15 minutes for several dates of service and bill the total, in whole units (15 minutes), at the end of the day, week or month, as long as care delivery is consistent with the written plan of care.

The following instructions apply to billing accrued units on separate detail lines of a claim:

- When billing each date of service, partial units may be accrued and billed on the first date a whole unit is accrued. For example, a provider delivers care from 10:00 a.m. to 11:40 a.m. on June 1, then provides care from 10:00 a.m. to 12:10 p.m. on June 4. Six (6) units of service are billed for June 1, and nine (9) units of service are billed on June 4.
- When billing multiple dates of service on one (1) detail line of a claim, total the time spent in minutes for each date, divide by 15, and bill the number of whole units. Do not round up to the nearest whole unit. For example, at the end of the month, time spent in the provision of personal care to an individual in a congregate living facility, who received services every day, totals 620 minutes. 620/15=41.33 units. Bill for 41 whole units of service.

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- When billing multiple dates of service on one (1) detail line of a claim, dates during which the client is in a hospital, in a nursing home facility, visiting relatives or is ineligible should not be included in the range of dates.
- When billing multiple dates of service on one (1) detail line of a claim, do not bill for dates of service falling in two (2) separate calendar months.

2.6 Authorized Nurse Visits

The authorized nurse visit is a covered service under the MO HealthNet Personal Care Program. Reimbursement is made for supervision of the Personal Care Program, in addition to the visits by a nurse to particular participants with special needs, when such visits are prior authorized by DHSS Division of Senior and Disability Services (DSDS) or its designee, or Bureau of Special Health Care Needs.

Providers of in-home agency personal care services must have the capacity to provide these authorized nurse visits as well as the non-authorized nurse supervision requirements outlined in the Personal Care Program standards.

The nursing services that may be authorized in the participant's home are services of a maintenance or preventative nature provided to participants with stable, chronic conditions. These services are not intended as treatment for an acute health condition and may not include services that are reimbursable as skilled nursing care under either the Medicare or MO HealthNet Home Health Programs. Should the provider nurse detect a need for services that meet the definition of reimbursable skilled nursing care under the Home Health Program, the provider nurse must alert the participant's physician and the appropriate state agency or its designee. The physician may then refer the participant to a home health agency for treatment.

Refer to the **Home Health Provider Manual** for more information.

To be eligible for the authorized nurse visit, the participant must receive a personal care service and have a documented need for the authorized nurse visit and have no adequate support system that could provide these services to the participant.

Authorized nurse visits are limited to 26 within a six (6)-month timeframe.

Authorized Nurse Services

The services of the nurse shall provide increased supervision to the personal care aide and maintenance or preventative services, assessment of the participant's health and the suitability of the service plan to meet the participant's needs. All advanced personal care participants must have at least one (1) authorized nurse visit per month. These services shall also include any referrals or follow-up action indicated by the nurse's assessment. In addition, these services must include one (1) or more of the following where appropriate to the needs of the participant and authorized by the appropriate state agency:

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- Filling insulin syringes in advance per manufacturer's instructions for a participant with diabetes who can self-inject the medication but cannot fill their own syringe. This service includes monitoring the participant's continued ability to self-administer the insulin. If the participant is otherwise eligible for services reimbursed through the Home Health Program, the authorized nurse visit through the Personal Care Program to pre-fill the syringes is not appropriate, since the service could and would be provided by the home health nurse.

NOTE: Manufacturers recommend that certain insulin should not be pre-filled into syringes.

- Setting up oral medications in divided daily compartments for a participant who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion
- Monitoring a participant's skin condition when a participant is at risk of skin breakdown
- Conducting health evaluations
- Providing nail care for a participant with diabetes or other medically-contraindicating conditions who is unable to perform this task, such as:
    - Circulatory or neurologic deficiency
    - Taking anticoagulant medications, such a Coumadin
    - Diagnosed with peripheral vascular disease
    - Diagnosed with compromised immune system, such as from human immunodeficiency virus (HIV) or chemotherapy
- Making a monthly on-site visit to each participant for whom advanced personal care services are authorized to evaluate the condition of the participant. A monthly visit report is documented through a provider using the **General Health Evaluation and Level of Care Recommendation form**. This document must be maintained in the participant's file. If critical issues are found during this on-site visit, the **Person Centered Care Planning (PCCP) Team** must be contacted immediately. The **General Health Evaluation and Level of Care Recommendation form** must be forwarded to the appropriate PCCP Team after completion.
- Providing on-the-job training and competency testing for advanced personal care aides

The state agency or its designee, at their discretion, may recommend authorization of nurse visits in other situations.

The authorized nurse visits listed above may be provided by a LPN or GN, if under the direction of a RN or physician. The services provided during the authorized nurse visit shall not include any service which the participant is eligible to receive under either the Medicare (Title XVIII) or MO HealthNet (Title XIX) Home Health Programs. The services listed above do not qualify, by

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themselves, for reimbursement under either program. However, should a participant otherwise be eligible for home health services, the above services will be provided by the home health agency.

It is the responsibility of the nurse to contact the participant's physician to obtain any necessary information or orders pertaining to the care of the participant. If the participant has an ongoing need for service activities that require more or less units than authorized, the nurse shall recommend in writing, that the plan of care be revised.

Authorized Nurse Administrative Requirements

The following administrative requirements must be maintained whenever the authorized nurse services are delivered. These requirements are in addition to the administrative standards of the Personal Care Program outlined in Section 2.2 of this manual.

The provider shall provide a general orientation for the nurse prior to the delivery of services which shall include instruction on the following:

- Code of ethics
- Participant's bill of rights
- Activities which shall or shall not be performed
- Infection control and universal precaution procedures as defined by the CDC
- Record keeping requirements and reporting forms required by the personal care provider or state agency, or its designee who authorized the service
- OSHA standards regarding precautions to be taken to avoid risks associated with bloodborne pathogens
- Communicating with the appropriate state agency or its designee and taking appropriate action on clinical changes in the participant's condition

Authorized Nurse Visit Records

Written notes concerning the authorized nurse's visits must be maintained in the participant's file. In addition, notes of any verbal communication and copies of any written communications with the participant's physician, other health care professional, or state agency or its designee concerning the care of that participant is also maintained in the participant's file.

2.7 Advanced Personal Care Services

The provision of advanced personal care (APC) services is an option available to providers under the MO HealthNet Personal Care Program. These advanced personal care tasks are maintenance services provided to assist a participant with a stable, chronic condition with ADLs when such assistance requires devices and procedures related to altered body functions.

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APC is a maintenance service and should never be used as a therapeutic treatment. Participants who develop medical complications requiring skilled nursing services while receiving advanced personal care services shall be referred to their attending physician who may, if appropriate, order home health services, inpatient care or institutionalization.

All personal care standards set forth in this section also apply to the Advanced Personal Care Program unless specifically stated otherwise. The requirements contained in this section are in addition to the Personal Care Program standards and pertain only to the delivery of APC services.

Personal care providers choosing to offer APC services are required to provide the following services:

- Routine personal care for persons with ostomies (including tracheostomies, gastrostomies and colostomies with well-healed stoma) and external, indwelling and suprapubic catheters. This care includes changing bags, and soap and water hygiene around ostomy or catheter site.
- Removal of external catheters, inspection of skin and reapplication of catheter
- Administration of prescribed bowel program, including use of suppositories and sphincter stimulation and enemas (pre-packaged only) for participants without contraindicating rectal or intestinal conditions
- Application of medicated (prescription) lotions, ointments, or dry, non-sterile dressings to unbroken skin
- Use of lift or other device for transfers
- Manual assistance with oral medications which are set up by a nurse
- Passive range of motion (non-resistive flexion of joint within normal range) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology
- Application of non-sterile dressings to superficial skin breaks or abrasions as directed by a nurse

APC Provider Participation Requirements

Providers choosing to deliver APC services must have a valid MO HealthNet Personal Care Provider Agreement in effect with MMAC, as referenced in **Section 2.1** of this manual. In addition, the provider must sign the **MO HealthNet Personal Care Program Addendum to Title XIX Participation Agreement for Personal Care Services**, indicating their agreement to provide APC services.

Only those personal care providers meeting one of the following requirements may sign the addendum; and subsequently, be authorized to provide APC services:

- Title XX (Social Service Block Grant) providers whose contract includes APC services
- A RCF or ALF licensed by DHSS Division of Regulation and Licensure

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Upon approval of the APC provider application, RCF/ALF APC providers may only furnish APC services to participants in their RCF/ALF. If a RCF/ALF provider wants to provide APC services in the community, it must submit a proposal to: MMAC Contracts Unit, PO Box 6500, Jefferson City, MO 65102-6500, and must receive approval as a Title XX Social Service Block Grant (SSBG) provider before services can be approved. Providers may contact MMAC at (573) 751-3399 for information regarding the SSBG provider program.

The **MO HealthNet Personal Care Program Addendum to Title XIX Participation Agreement for Personal Care Services** and verification of the Title XX contract should be submitted to: MMAC Contracts Unit, PO Box 6500, Jefferson City, Missouri 65102-6500.

APC Participants Minimum Needs Criteria

In addition to meeting the eligibility requirements of the Personal Care Program listed in **Section 2.1** of this manual, the participant must have a documented need for the APC service(s) and have no adequate support system that could provide these services to the participant. The participant must have a qualifying stable, chronic condition and need assistance with ADLs when such assistance requires devices and procedures related to altered body functions. Participants are assessed as eligible for personal care or APC by one (1) of the following DHSS agencies or their designees: Division of Senior and Disability Services (DSDS), Bureau of Special Health Care Needs (BSHCN), or Bureau of HIV, STD, and Hepatitis (BHSH). For children, reference **Section 2.13** and **Section 2.14** of this manual. For persons with AIDS/HIV, reference **Section 2.15** of this manual.

Authorization of APC

All units of APC must be authorized by DHSS or its designee before services can be delivered. The plan of care must be developed, reviewed and updated by the provider's RN in cooperation with the state agency or its designee. For APC services authorized by BSHCN for children (age 0-20 years), the advanced personal care plan must be updated every six (6) months.

APC Registered Nurse Supervision

RN supervision is essential to the safe provision of APC services. Certain nurse functions for APC participants may be performed by a LPN or GN; others must be performed by a RN. The following outlines the nursing requirements for APC participants:

RN requirements:

- Conduct an initial assessment visit and develops the plan of care for participants with APC needs, in collaboration with the state agency staff or its designee. The provider may request a change in the plan of care if determined through this initial assessment. This request should be made to the appropriate DHSS staff. This visit may be authorized and billed to MHD as an authorized nurse visit.
- Conduct on-site visits to all APC participants at intervals no greater than six (6) months. During the visit, the RN must conduct and document an evaluation of the participant's condition, continued eligibility for the program, and the adequacy of the plan of care. The

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RN must sign the evaluation and the provider shall maintain documentation of the evaluation in the participant's record. The evaluation must be produced upon request of DSDS or MMAC.

- Ensure they are available, at least by telephone, during any period of time APC is being provided
- Observe the successful execution by the aide of each APC task during an on-the-job training session, and personally certifies the successful completion of the task in the aide's personnel record. This visit may be authorized and reimbursed. NOTE: A LPN or GN may observe the successful execution and personally certify the successful completion of each APC task, if the LPN or GN is trained in the APC tasks and observed by the RN supervisor for successful completion of each task, and it is personally certified by the RN supervisor in the LPN's or GN's personnel record.

A LPN or GN may, under the direction of a RN:

- Conduct the monthly authorized nurse visit to evaluate the condition of the APC participant and the adequacy of the plan of care to meet the needs and conditions of the participant, including a review of the plan of care with the participant.
- Observe the successful execution by the aide of each APC task during an on-the-job training session and personally certify the successful completion of the task in the aide's personnel record, if the LPN or GN is trained in the APC tasks and observed by the RN supervisor for successful completion of each task and it is personally certified by the RN supervisor in the LPN's or GN's personnel record. This visit may be authorized and reimbursed.

APC Aide Requirements

In addition to meeting the basic personal care aide requirements discussed in **Section 2.3** of this manual, all APC aides employed by the provider must:

- Not be a family member of the participant for whom personal care is to be provided, as defined in **Section 2.1** of this manual; and
- Be a LPN or a certified nurse assistant; or
- Be a competency-evaluated home health aide having completed both written and demonstration portions of the test required by the Missouri Department of Health and Senior Services and **42 CFR 484.80**; or
- Have successfully completed personal care aide training

APC Aide Training

APC aides must receive a minimum of six (6) hours of APC training, prior to the provision of any APC tasks, in addition to the required basic training for personal care aides as described in this manual.

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The provider shall have written plans of the training; such training must include at a minimum the following topics:

- Observation of the participant and reporting observations
- Application of ointments/lotions to unbroken skin
- Manual assistance with oral medications
- Prevention of decubiti
- Enemas
- Basic personal care for persons with ostomies and catheters
- Proper cleaning of catheter bags
- Bowel routines (rectal suppositories, sphincter stimulation)
- Passive range of motion exercises
- Use of assistive device (i.e., lifts, transfer boards, etc.) for transfers
- Positioning and support of the participant
- Applying non-sterile dressings to superficial skin breaks
- Universal precaution procedures as defined by the CDC

The provider must document the dates and hours of the APC training received by the personal care aide in the aide's personnel file.

Waiving Training Hours

The provider may waive the six (6) hours of APC training if one (1) of the following conditions are met:

- The proposed APC aide is a certified nurse assistant or a LPN currently licensed or registered in Missouri
- The proposed APC aide has previously completed APC training from a Missouri Medicaid in-home provider agency and has been employed by a Missouri Medicaid in-home provider as a APC aide within the prior six (6) months

If the waiver of APC training has been granted, documentation that the above conditions have been met must be placed in the aide's personnel record and be available for inspection.

Demonstration of Competency

Prior to performing any APC task for any participant for the first time, the APC aide who is not a licensed nurse must demonstrate competency, specifically for the APC tasks as they appear on a participant's plan of care. This competency must be demonstrated in an on-the-job training session

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conducted by a RN, LPN or GN. The RN, LPN or GN must document the aide's competency in performing each task in the aide's personnel file. The required demonstration of each APC task during an on-the-job training session with a RN, LPN or GN may not be waived, unless the APC aid is a licensed nurse. RN, LPN or GN visits necessary for task observation and certification in the home may be prior authorized and billed to MHD as an authorized nurse visit. RN, LPN or GN task observation and certification in a laboratory, or other non-home setting, may not be billed.

The RN, LPN or GN may observe the execution of any of the tasks in a participant's home or lab setting. However, it is the responsibility of the provider to ensure the aide is properly trained to execute tasks that may have variation from the lab setting to the participant's home setting.

Annual In-Service Training

APC aides must receive five (5) hours of annual in-service training, the same as any personal care aide, as described in **Section 2.4** of this manual.

APC Records

Providers participating in the delivery of APC services must maintain all records and documentation required of the MO HealthNet Personal Care Program. In addition, the following records and documentation that pertain only to the delivery of APC services must be maintained by participating providers.

APC Aide's Personnel Record

The aide's personnel record shall contain:

- Documentation of the six (6) hours of APC training including dates and topics
- Documentation for any waiver of the six (6) hours of APC training
- Signed statement(s) by the RN, LPN or GN, certifying that the aide has successfully completed on-the-job training for each APC task the aide is required to perform

APC Participant's Record

The case record of any participant receiving APC services shall include:

- Written notes concerning any authorized nurse visits including the six (6)-month supervisory visit and the monthly nurse visit report. In addition, notes of any verbal communication and copies of any written communication with the participant's physician or other health care professional, concerning the participant's care must be maintained in the participant's case record.
- A closing summary documenting that 21-day notification was given to DHSS or its designee, and the APC participant prior to the date of closing, the participant's authorization date, the most recent plan of care including identified functional disabilities, the reason for closing, the date of closing, and a follow-up plan, if applicable.

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2.8 Personal Care Assistance - Consumer-Directed Services General Program Information

The Personal Care Assistance (PCA)-Consumer-Directed Services (CDS) program is authorized by DHSS/DSDS. PCA-CDS are services that are required or may be provided as part of the CDS Program.

Under CDS, the consumer is responsible for hiring, training, supervising, and directing the personal care attendant.

Authorization of CDS is funded through both the Medicaid State Plan and the 1915(c) Home and Community-Based Services waiver titled Independent Living Waiver (ILW). This policy addresses the Medicaid State Plan services only.

Requirements and responsibilities for both CDS consumers and providers are established in **19 CSR 15-8**.

CDS Personal Care Tasks

Transportation assistance for essential shopping, errands, school, or employment is an allowable CDS task when the participant has an identified need for personal care assistance, even if that is met by supports other than CDS.

Refer to **Section 2.1** and **Section 2.7** of this manual for additional examples of personal care tasks and advanced personal care tasks that may be authorized under CDS.

CDS Service Limitations

All CDS consumers must be capable of living independently (reside in a non-institutional or unsupervised residential setting) with CDS in place.

CDS shall not be authorized to pay for services when:

- The primary benefit is to a household unit
- The task is something that members of a household may reasonably be expected to share or do for each other, unless the task is above and beyond typical activities that would be provided for a household member without a disability

CDS provides "hands on" assistance with physical tasks that benefit the consumer and are based on the physical limitations of the participant. Therefore, no time can be allotted for:

- Stand-by assistance, prompting, or cueing
- Respite care or for time spent waiting for a consumer at a physician's office, or any other appointment
- Any task that must be performed/trained by a licensed professional (i.e., skilled nursing, therapies ordered by a physician, etc.)

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An individual with a physical disability whom also has a cognitive impairment that does not affect their ability to self-direct is authorized for CDS through the Independent Living Waiver only; these consumers cannot be authorized for CDS through the State Plan.

Individuals authorized for any type of residential habilitation services through DMH shall not be authorized for CDS as outlined in this policy. Individualized Supported Living (ISL) is considered a residential habilitation service. To facilitate service coordination, the 'Medical Hx' (History) tab within **CyberAccess** provides a procedure link. If the participant is enrolled in CDS, they cannot also participate in DMH Division of DD self-directed services.

CDS Provider Participation and Notification Requirements

CDS providers must have a valid MO HealthNet Personal Care Provider Agreement in effect with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance Unit (MMAC), and must adhere to the standards for notification of provider changes and updates. Refer to **Section 2.1** of this manual for further information on provider participation and notification requirements.

Electronic Visit Verification

In accordance with the 21st Century CURES Act and **13 CSR 70-3.320**, providers are required to utilize an electronic visit verification (EVV) system to document services rendered related to the delivery of in-home services for all Medicaid-funded agency and consumer-directed (CDS) personal care services. The EVV system must have the ability to exchange data with the EVV Aggregator Solution. Refer to **Section 2.1** of this manual for additional information regarding EVV.

CDS Consumer Eligibility Requirements

In addition to participant eligibility requirements listed in **Section 2.1** of this manual, CDS consumers must meet the following eligibility criteria:

- Be at least 18 years of age
- Have a physical disability (loss of, or loss of use of, all or part of the neurological, muscular or skeletal functions of the body to the extent that the person requires the assistance of another person to accomplish routine tasks)
- Be able to self-direct their own services/care (consumer-directed)
- Be capable of living independently with CDS in place

Authorization of CDS

All units of Title XIX personal care services must be authorized by DHSS or its designee before services can be delivered. Refer to **Section 2.1** of this manual for additional information regarding authorization of services.

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2.9 Personal Care Assistance - Consumer-Directed Services Administrative Requirements

CDS Consumer Responsibilities

CDS consumers are responsible, at a minimum, for the following:

- Selection, hiring, training, and supervision of the personal care attendant
- Allowing the use of an EVV system that documents in-home personal care services delivery, in accordance with **13 CSR 70-3.320**
- Ensuring that units submitted for reimbursement do not exceed the amounts authorized by the CDS plan of care and/or those eligible for reimbursement through MHD
- Promptly notifying DSDS and/or the provider within 10 days of any changes in circumstances affecting the CDS plan of care and/or changes in the consumer's place of residence
- Promptly notifying the provider of any problems resulting from the quality of services rendered by the attendant. Any problems not resolved with assistance from the provider shall be reported to DSDS.
- Providing the provider with all necessary information to complete required paperwork for establishing the employer identification number
- Allowing the provider to comply with its quality assurance and supervision process, which shall include, but not be limited to, annual face-to-face home visits and monthly case management activities
- Reporting to DSDS significant changes in their health and ability to self-direct care by contacting the provider and/or DSDS

CDS Provider Administrative Requirements

CDS providers must designate to MMAC the CDS manager who will be responsible for the provider's day-to-day operation. Refer to **Section 2.10** of this manual regarding specific CDS personnel requirements for this manager.

CDS providers must implement a quality assurance and supervision process that ensures program compliance and accuracy of records, including ensuring the CDS manager adheres to the personnel requirements in **Section 2.10** of this manual, and maintaining documentation of successful completion of such requirements.

CDS providers must have a written pandemic preparedness policy to be followed when service delivery must be interrupted due to a pandemic, and providers must distribute their pandemic preparedness policy to all consumers annually. Providers must train all consumers and attendants on the policy at least annually.

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CDS providers must perform, directly or by contract, payroll and fringe benefit accounting functions for consumers, including but not limited to:

- Utilizing an EVV system to document in-home personal care services rendered, in accordance with **13 CSR 70-3.320**, collecting EVV records and verifying accuracy
- Transmitting individual payments directly to the personal care attendant on behalf of the consumer
- Ensuring all payroll, employment, and other taxes are filed and paid timely under the consumer's tax ID number
    - The provider shall be liable to the consumer for any garnishment action occurring as a result of the provider's failure to timely pay payroll, employment, or other taxes on behalf of the consumer.
    - The provider shall notify the consumer of any communications or correspondence from any federal, state, or local tax authority of any overdue or unpaid tax obligation, as well as any notice of an impending garnishment.
    - The provider may be subject to a monetary penalty per occurrence of the provider's failure to timely pay payroll, employment, or other taxes on behalf of the consumer.

In addition to the above requirements, CDS providers are responsible, directly or by contract, for the following:

- Completing the MHD reimbursement process, including the filing of claims and reporting data to MHD as required by rule
- Maintaining a list of eligible attendants:
    - Ensuring that each attendant is registered, screened, and employable according to the FCSR, the Office of Inspector General (OIG) and the EDL maintained by DHSS, and applicable state laws and regulations prior to beginning service delivery
    - Notifying the attendant of their responsibility to comply with applicable state laws and regulations regarding reports of abuse or neglect
    - Attendants must meet the CDS attendant personnel requirements as outlined in **Section 2.10** of this manual.
- Training and orientation of consumers in the skills needed to recruit, employ, instruct, supervise and maintain the services of attendants. Refer to **Section 2.11** of this manual for further information regarding CDS consumer training requirements.
- Processing of consumers' and/or attendants' inquiries and problems

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- Performing public information, outreach and education activities to ensure that persons with disabilities are informed of the services available and have maximum opportunity for participation
- Maintaining confidentiality of consumer records, including eligibility information from DSDS, according to applicable federal and state laws and regulations
- Performing ongoing monitoring of the provision of services in the plan of care and assessing the quality of care being delivered. Such monitoring shall include:
    - At least one (1) annual face-to-face visit in the participant's home as outlined in **RSMo Section 208.918**. Face-to-face is defined as an interaction that occurs in person and does not include interactions that occur through telecommunication or electronic technologies. Face-to-face visits shall be completed within 365 days from original authorized plan of care, and annually thereafter. Documentation of each face-to-face visit must contain, at a minimum, the name of the monitoring individual, those present at the time of the visit, service delivery evaluation summary, the quality of care being delivered, and date and time of the visit. All documentation must be maintained in the consumer's case file and shall be made available to DHSS upon request. The provider shall report to DHSS if services are not being provided to the consumer as authorized in the plan of care, which may result in suspension of services to the consumer.
    - Monthly case management activities which must be completed by telephone, videoconference, or in-person with the consumer
    - Other monitoring may include electronic monitoring, telephone checks, written case notes, or other DHSS-approved methods. The ongoing monitoring shall not preclude the provider's responsibility of ongoing diligence of case management activity oversight.
- Ensuring the consumer has an emergency and/or back up plan
- Reporting to DHSS significant changes in the consumer's health or ability to self-direct care
- Ensuring that the consumer's case file contains, at a minimum, the required documentation outlined in **Section 2.12** of this manual
- Adhering to the CDS provider service delivery standards outlined in this section

CDS providers must comply, directly or by contract, with the following fiscal requirements:

- No state or federal funds shall be authorized or expended to:
    - Pay for CDS if the primary benefit of such services is to the household unit, or is a task that members of the consumer's household may

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reasonably be expected to share or do for each another, unless such service is above and beyond typical activities household members may reasonably provide for another household member without a disability

- Pay for CDS provided by an attendant who is listed on any of the background check lists in the **Family Care Safety Registry** pursuant to applicable state laws and regulations, unless a good cause waiver is first obtained by the attendant from DHSS in accordance with applicable state laws and regulations
- Pay for personal care assistance services if any direct employee of the CDS provider conducts the face-to-face home visit of a consumer for whom such employee is also the attendant, unless such person provides services solely on a temporary basis on no more than three (3) days in a 30-day period. The certified manager shall maintain records and provide to MMAC upon request.

- The general assembly shall set the statewide reimbursement rate to be paid for CDS.
- The total monthly payment for CDS made on behalf of a consumer shall not exceed 60% of the average statewide monthly cost for care in a nursing facility as defined in applicable state laws and regulations.
- Assure that federal funds shall not be used to replace funds from non-federal sources and that the provider shall continue or initiate efforts to obtain support from private sources or other public organizations
- Be responsible for repayment of any federal or state funds that are deferred and/or ultimately disallowed
- Submit CDS Quarterly Financial and Service Reports to MMAC 30 days after the end of each calendar quarter
- Submit an Annual Service Report to MMAC by January 30th of the following year (Example: report for 2024 due January 30, 2025)
- Maintain CDS financial records separately from any other financial records and make all consumer and CDS financial records, documents, reports and data available to MMAC upon request
- Submit an annual audit or review by a properly-licensed independent practitioner (certified public accountant licensed in the State of Missouri) pursuant to applicable federal and state laws and regulations, including any audit parameters as established by DHSS
  - An annual financial statement audit is required if the provider's annual gross revenue is $200,000 or more.

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- An annual financial statement audit or annual financial statement review is required if the provider's annual gross revenue is less than $200,000.
- The audit report must be submitted to MMAC within 150 days after the end of the provider's fiscal year.

CDS Provider Service Delivery Standards

In addition to the provider service delivery standards outlined in **Section 2.2** of this manual, CDS providers must comply with the following:

- Have a philosophy that promotes the consumer's ability to live independently in the most integrated setting. This philosophy includes the following independent living services:
  - Advocacy
  - Independent living skills training
  - Peer counseling
  - Information and referral
- Operate programs, services, and/or activities in such a manner as to be readily-accessible to and usable by persons with disabilities.
- Demonstrate a positive impact on consumer outcomes regarding the provision of CDS, by submitting quarterly service reports and an annual service report to MMAC
- Adhere to applicable statutes and regulations regarding reports of misappropriation of a consumers' property or funds or the falsification of documents verifying CDS delivery

CDS Consumer's Rights and Procedures

CDS providers shall have a written statement of the consumer's rights to be given to each consumer at the time service is initiated. Refer to **Section 2.2** of this manual for more information.

CDS Discharge Policies and Procedures

The following CDS discharge policies and procedures are in addition to those outlined in **Section 2.2** of this manual.

Upon discovery, CDS providers shall refer the following situations that may require closure or termination of services to DSDS for investigation:

- The inability of the consumer to self-direct
- Significant changes which would result in the need of a change in the authorized plan of care for the consumer

CDS providers, after giving notice to DSDS:

- May suspend services to consumers in the following circumstances:

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- The personal care attendant witnesses significant deterioration of the health of the consumer or has a belief that the consumer is no longer capable of self-directed care
- Falsification of records or fraud, including providing false information of their condition(s), functional capacity, or level of care needs during the assessment that resulted in an authorization of services not needed
- Persistent actions by the consumer of noncompliance with the plan of care which negate the services provided in the plan of care, and all alternatives have been explored and exhausted
- The consumer or a member of the consumer's household threatens and/or abuses the attendant and/or provider to the point where the staff's welfare is in jeopardy and corrective action has failed
- The attendant is not providing the services outlined in the CDS plan of care and attempts to remedy the situation have been unsuccessful

- Shall provide written notice to DSDS and the consumer, listing the specific reasons for requesting the closure, termination or suspension. All supporting documentation must be maintained in the consumer's case file. DSDS shall investigate the circumstances reported by the provider and assist the consumer in accessing appropriate care. If the investigation concludes that such circumstances exist, DSDS may close or terminate services.

CDS Provider Compliance

In addition to the provider compliance requirements outlined in **Section 2.2** of this manual, CDS providers must:

- Provide proof of maintaining a business location that complies with any and all applicable city, county, state and federal requirements upon request of MMAC
- Have staff on the premises of the principal place of business that have access to records during business hours as prescribed by the provider's written agreement with MMAC

2.10 Consumer-Directed Services Personnel Requirements

The CDS attendant is an employee of the consumer only for the time period subsidized with CDS funds, but is never the employee of the provider, DHSS or the State of Missouri. CDS attendants must meet the following qualifications:

- Be at least 18 years of age
- Be able to meet the physical and mental demands required to perform specific tasks required by a particular consumer
- Agree to maintain confidentiality

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- Be emotionally mature and dependable
- Be able to handle emergency-type situations
- Be a person other than the consumer's spouse or guardian
- Not be a consumer
- Have not been involved in Medicaid fraud previously

The CDS manager is responsible for the provider's day-to-day operation. This manager must:

- Be a policy maker and supervise the provider's record keeping, service delivery verification, training and orientation of consumers in skills needed to recruit, employ, instruct, supervise and maintain the services of attendants
- Successfully complete (or have completed) the CDS certified manager orientation and test offered by MMAC. Completion of the test for all new managers is required within six (6) months of hire
- Annually attend a MMAC-sponsored training update CDS meeting

CDS providers and managers must maintain documentation of attendance for all training, testing and meetings.

2.11 Consumer-Directed Services Consumer Training

Documentation must be kept in the CDS consumer's file regarding training provided to the consumer in the skills needed to understand and perform the essential functions of an employer.

Training and orientation of consumers in the skills needed to recruit, employ, instruct, supervise, and maintain the services of attendants include, but are not limited to:

- Assisting consumers in the general orientation of attendants as requested by the consumer. To the fullest extent possible, this shall take place in the presence of the attendant.
- Federal and state requirements regarding the mandatory use of EVV to document services delivered
- Identification of issues that would be considered fraud, including falsification of attendant visit verification records, and notification to the consumer that such issues shall be reported to MMAC
- Responsibility of the consumer to report fraud to DHSS and/or MMAC
- Allowable and non-allowable tasks
- Rights and responsibilities of the attendant
- Identification of abuse, neglect, and/or exploitation

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- The attendant shall report to DHSS and/or the provider if they witness significant deterioration of the health of the consumer or if they have a belief that the consumer is no longer capable of self-directed care. Failure of the attendant to report this information should be reported by the provider to DHSS.

CDS consumers must receive training at least annually regarding the provider's pandemic preparedness policy to be followed when service delivery must be interrupted due to a pandemic. Refer to **Section 2.9** of this manual for more information regarding this provider requirement.

2.12 Consumer-Directed Services Consumer Records

CDS Consumer Case Record

CDS providers are required to document, at a minimum, the following in CDS consumer case files:

- Employee Identification Number (EIN) and Missouri Tax ID
- Documentation that all payroll, employment and other taxes are filed and paid timely under the consumer's EIN, as outlined in **Section 2.9** of this manual
- Documentation of ongoing monitoring of provision of services, including monthly case management activities and annual face-to-face visits, as outlined in **Section 2.9** of this manual
- Written plan of care and service authorization that document the type of services and quantity of units to be provided
- Documentation of use of EVV in accordance with **13 CSR 70-3.320**
- Copies of all correspondence with DSDS, the consumer's physician, other service providers, and other administrative agencies
- Documentation of training provided to the consumer in the skills needed to understand and perform the essential functions of an employer
- Documentation of the consumer's emergency and/or backup plans
- Signed documentation that the consumer has been informed of their rights concerning hearings and consumer responsibilities
- Any pertinent documentation regarding the consumer

Adequate Documentation

All services provided must be adequately documented in the medical record. For information regarding adequate documentation and adequate medical records, refer to **Section 2.5** of this manual.

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Providers are required to utilize an EVV system to document services rendered related to the delivery of in-home services for all Medicaid-funded agency and consumer-directed personal care services. Refer to **Section 2.1** of this manual for more information regarding EVV.

CDS providers are required to document that all payroll, employment and other taxes are filed and paid timely under the consumer's EIN.

2.13 Personal Care Services for Children Through Healthy Children and Youth Program

The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) mandated expanded services to children through the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT). In summary, OBRA '89 requires states to provide medically necessary treatment for children for conditions or problems identified through the EPSDT health screen, even if the needed medical service is beyond the scope of the state's MO HealthNet state plan. While personal care is a service under the State Plan in Missouri, historically the service has been utilized by few children. Children with serious home care medical needs were served through the Children's Waiver prior to OBRA '89, which included private duty nursing, home health, therapy, supplies, and aide service.

Missouri implemented the mandates of OBRA '89 through the Healthy Children and Youth (HCY) Program. Many of the services now available to children under the HCY Program are prior authorized by the BSHCN of the Department of Health and Senior Services.

Refer to the **Healthy Children and Youth Provider Manual** for additional information regarding the HCY Program.

Authorization

Personal care services for MO HealthNet-eligible children (aged 20 and under) may be authorized by BHSH. There are major differences in services for children and services for adults. In cases of personal care for a child, the provider agency may receive a referral directly from a family, hospital, physician, or other referral source. The provider may then request approval for prior authorization from BSHCN.

Children are determined to be in need of personal care by medical necessity, rather than by being assessed to have nursing home level of care needs. An example of a personal care need for a child is one who needs total personal care, or requires extra assistance in bathing, toileting, eating, or other ADLs, because of a medical condition. The fact that a child has a caretaker does not make the child ineligible for personal care.

Reimbursement for personal care services delivered to children enrolled in MO HealthNet's Managed Care Program are the responsibility of the health plan in which the children are enrolled. Charges for services provided to MO HealthNet Managed Care enrolled children may not be billed to MHD. Health plans participating in the MO HealthNet Managed Care program are responsible for arranging, authorizing and reimbursing for all personal care delivered to enrollees. For more information about MO HealthNet's Managed Care program, please reference **Section 2.16** of this manual.

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Medical Criteria

The following is a list of examples of medical problems that meet the criteria for medical necessity for personal care services for children. This list is not exhaustive and only provides a guideline of conditions.

Children who:

- Have poorly controlled seizures, other than severe generalized tonic/clonic (grand mal) seizures
- Require assistance with orthotic bracing, body casts, or casts involving one (1) full limb or more (A typical short or long arm cast on an otherwise healthy child does not necessitate services of a personal care aide.)
- Are incontinent of bowel and/or bladder at age four and after (chronic bedwetting and encopresis excluded)
- Have persistent and/or chronic diarrhea, regardless of age
- Have significant central nervous system damage affecting motor control
- Have organically-based feeding problems
- Require assistance with ADLs (applies to children unable to perform age-appropriate functions of bathing, maintaining a dry bed and clothing, toileting, dressing, and feeding). Children with a diagnosis of developmental or intellectual disability may be eligible for personal care, if their ability to perform age-appropriate personal care is impaired.

The following are examples of cases where personal care services are not appropriate for a child:

- Cases that require skilled nursing services. These services are available through the Home Health and the Private Duty Nursing Programs. Refer to the **Home Health Provider Manual** or the **Private Duty Nursing Provider Manual** for more information.
- When there is no documented medical need for the care. For example, personal care for a healthy infant or toddler with no medical problems is inappropriate, as parents or other caregivers are expected to meet those needs as a normal function of parenting. However, when a child's personal care needs are greater than those of a healthy child of the same age, because of a medical condition or disability, then personal care may be appropriate to assist the caregiver in meeting those additional needs.
- Respite or baby-sitting service. Personal care services must include the performance of direct hands-on assistance and cannot consist solely of oversight or supervision. If a parent must be gone from the home when the personal care is needed, a personal care aide may deliver the service while the parent is absent, as long as the child has a medical need for the service.

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- Homemaker-only service. While some homemaking service is appropriate through the Personal Care Program, such as changing bed linens or meal preparation and clean-up, homemaker services should represent only a small portion of the Personal Care Plan for Children. A parent or caretaker who is unable to perform the homemaking tasks because of their own disability may be referred to DSDS for assessment. In these cases, both the parent and child may be authorized for personal care services.

The following are examples of cases where personal care services are appropriate for children. These examples are not all inclusive, and are not intended to describe the only situations in which personal care for children may be authorized. These case descriptions are meant to be used as a guide for providers to use in deciding whether or not to accept a referral and to request prior authorization.

- A 13-year old child who uses a wheelchair and needs assistance with breakfast and getting ready for school. The parent must leave for work at 6:30 a.m., too early to get the child ready for the bus. The child is of an age appropriate to get their own breakfast and get dressed for school, and has personal care needs.
- A 15-year old child with a disability who weighs 150 pounds. The parent is at home, and is available to provide the care; however, the child is too large for the parent to manage safely alone.
- A parent has four (4) children, ages five (5) and under. The five (5)-year old child needs personal care due to a medical condition. The other three (3) children have no medical problems. If the child were an only child, personal care is questionable, in spite of the disability, because of the availability of the parent. However, the needs of the three (3) additional children render the parent unavailable to meet the extra personal care needs of the child with disabilities.
- An emancipated young adult under 21, with personal care needs following surgery or an injury.

Family as Caregivers

The availability of the parent should be considered when developing a plan of care, but should not be a reason why personal care is denied. The plan of care should describe in detail why the parent is unable to provide personal care themselves, or why they need assistance.

A parent's or other caregiver's outright refusal to accept some responsibility for the care of a child should be reported to the Child Abuse/Neglect hotline, (800) 392-3738. The personal care plan must be implemented with some assistance and cooperation of the normal caregiver.

The aide employed by the agency who actually delivers the personal care service must not be a family member, as defined in **Section 2.1** of this manual.

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Plan of Care Development and Registered Nurse Services

The initial Personal Care Plan for Children must be developed by a RN. The agency may bill MHD separately for the initial evaluation and plan of care development when a face-to-face evaluation of the child is conducted. An evaluation procedure code, which does not require prior authorization, may be billed twice per year, per agency, per child. The RN evaluation is reimbursed at the same rate as the prior authorized nurse visit in the Personal Care Program designed for the adult population. Refer to **Section 5** of this manual for procedure codes. The RN assesses and evaluates the child, develops the plan of care, and obtains the physician's approval. The plan of care and the physician's approval must be submitted to BSHCN with the **Prior Authorization Request**. Refer to **Section 3** of this manual for information on documentation.

Based on the plan of care developed by the RN, the personal care provider submits a request for approval for a specific number of units of personal care service to be delivered to the child. The personal care plan should specify the number of units per day, the frequency they will be delivered, the duration of service (how many weeks or months) and the specific tasks the aide is expected to perform. Personal care is authorized in one (1)-month increments for up to six (6) months per **Prior Authorization Request**.

The provider may request prior authorization for additional nurse visits, on a weekly basis, if the plan of care indicates the child's condition may change and should be reassessed frequently. The authorized nurse visit may be used also for extra supervision of the aide. For example, in the case of a child with chronic diarrhea, nurse visits may be necessary to reassess the plan of care frequently, as well as to monitor the child's skin condition.

The personal care provider may request prior authorization for RN visits to evaluate the child prior to requesting reauthorization, if this must be done more often than twice per year. If assessment is required twice per year or less, it should be billed via the nurse evaluation procedure code, which does not require prior authorization. Refer to **Section 5** of this manual for procedure codes.

The authorized nurse visit in the Personal Care Program should not be confused with the services available through the Home Health Program. Cases in which the nurse is needed for skilled treatment of acute conditions should be authorized for the skilled nurse visit in the Home Health Program or the Private Duty Nurse Program. Refer to the **Home Health Provider Manual** or the **Private Duty Nursing Provider Manual** for more information.

Advanced Personal Care Services for Children

Children who require devices and procedures relating to altered body functions may be eligible for advanced personal care services. The provider agency may request prior authorization from BSHCN. Advanced personal care services for children must be delivered in accordance with the training and supervisory requirements for advanced personal care, as described in **Section 2.7** of this manual.

In developing the plan of care that includes advanced personal care, the provider must be specific about the length of time that is required each day for advanced personal care. Only the times

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designated specifically as advanced personal care may be reimbursed at the higher rate. All other time must be authorized and reimbursed at the basic personal care rate.

Medically Fragile Adult Waiver

The Medically Fragile Adult Waiver (MFAW) was designed to provide HCBS to individuals who have reached the age of 21 and are no longer eligible for services through the HCY Program. Private duty nursing, specialized medical supplies, and waiver attendant care services may be authorized through this waiver. Services for the MFAW require prior authorization by BSHCN. Refer to the **Medically Fragile Adult Waiver Manual** for more information.

2.14 School-Based Individualized Education Plan Direct Services

Personal Care Individualized Education Plan (PC IEP) services are included in the school-based IEP services program for public and charter schools. The program allows for the school district to receive the federal match portion of the funds allocated for certain medical services. Only the services identified in the IEP and up to the amount and duration identified in the IEP will be considered reimbursable.

School-based PC IEP services are medically-oriented maintenance of services designed to assist with ADLs during the course of the school day. PC IEP services are medically-oriented tasks that are reviewed and approved or certified by a physician as the care necessary to meet a participant's personal, physical needs and thereby enable the participant to attend school. PC IEP services are intended to meet personal, physical requirements and to meet needs that cannot be met by other resources. PC IEP services must be provided by a qualified individual who is not a member of the participant's family, as defined in **Section 2.1** of this manual. The school district must monitor the overall physical care needs of the participant while in the school setting and contact the participant's physician if the participant's condition warrants.

The procedure code for billing PC IEP services in a school setting is T1019 TM. This service is billed in 15-minute increments. All services must be logged and billing is based on the time spent providing a covered service. Observation and waiting time are not covered. Refer to **Section 5** of this manual for more information on procedure codes.

To participate in the school-based PC IEP program, the billing provider of the services must be a recognized public school district in the State of Missouri by the Department of Elementary and Secondary Education (DESE). These services are billed by and reimbursement is made only to the school district. The school district may provide PC IEP services directly or through contract with a personal care provider agency.

If the school district chooses to contract for PC IEP services, the arrangements made by the school district with the actual Personal Care provider agency are between the school district and the provider agency. The personal care provider agency must be a MO HealthNet-enrolled personal care provider and cannot bill directly for MO HealthNet school-based PC IEP services.

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For school districts who do not contract with a MO HealthNet-enrolled personal care provider agency, all personal care requirements as set forth in **13 CSR 70-91** must be met. A school district providing direct PC IEP services must meet the criteria for a personal care provider agency. The school district must submit a written proposal describing the service delivery system, assure understanding and compliance with the standards of the personal care program, and document the agencies administrative and fiscal ability to provide the services in accordance with these standards. Proposals will be reviewed by qualified medical staff or designees of DSS.

The administrative requirements that must be addressed in the school district's written proposal are as follows. The school district must:

- Maintain bonding, and personal and property liability insurance coverage on all employees involved in delivering PC IEP services
- Have a policy for responding to emergency situations
- Outline how qualified providers will be maintained, including supervisory requirements
- Outline available training and how training documentation will be maintained
- Have a written statement of the participant's Bill of Rights, which shall be given to the parent/guardian at the time the service is initiated. At a minimum, the statement should say the participant has the right to:
    - Be treated with respect and dignity
    - Have all personal and medical information kept confidential
    - Have direction over the services provided as stated in the IEP
    - Know the school district's established grievance procedure and how to make a complaint about the service and receive cooperation to reach a resolution without fear of retaliation
    - Receive services without regard to race, creed, color, age, sex, or national origin
    - Receive a copy of this Bill of Rights
- Have a written grievance policy which shall be provided to each participant and parent/guardian upon initiation of services. The grievance policy must also include the phone number of the Constituent Services Unit at (800) 392-2161.
- Report all instances of possible child abuse or neglect to the Child Abuse/Neglect (CA/N) Hotline, (800) 392-3738. Any suspected abuse or neglect by a school district employee, including personal care staff, must be reported according to **RSMo 210** and could be subject to prosecution. Failure to report by a mandatory reporter (personal care staff would be considered mandatory reports) is a violation of **RSMo 210.115** and could be subject to prosecution.

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- Maintain the distinction of a public school district with DESE

Whether services are provided directly by the school district or through contact with a personal care agency, the PC IEP services are limited to those providers who meet licensing and supervisory requirements for the PC IEP program.

Personal Care Aide

A school-based personal care aide shall meet the following requirements:

- Be at least 18 years of age
- Be able to read, write and follow directions
- May not be a family member of the participant for whom personal care is to be provided, as defined in **Section 2.1** of this manual
- Must be available to provide care in accordance with the personal care plan, utilizing universal precaution procedures as defined by the CDC
- Prior to the delivery of service, the personal care aid shall receive a copy of the plan of care for the participant and be provided with information about the participant in order to appropriately deliver services to meet the needs of the participant.
- Newly-employed aides must receive the following orientation and personal care training:
    - Orientation: 12 hours of orientation training within 30 days of employment, that includes at least two (2) hours' orientation to the school district and the school district protocols for handling emergencies, and a minimum of six (6) hours of training completed prior to participant contact
    - Four (4) hours of required training may be waived with adequate documentation in the personal care aide's records that the aide received similar training during the previous 12 months.
    - If the personal care aide is a certified nurse assistant, LPN, or RN, the school district may waive all hours of orientation training, with the exception of the two (2) hours' school district orientation, with adequate documentation placed in the personal care aide's personnel record. The documentation shall include the employee's license or certification number, which must be current and in good standing at the time the training was waived.
- An additional five (5) hours of in-service training annually are required after the first 12 months of employment.

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- The school district may waive the required annual five (5) hours of in-service training and require only two (2) hours of refresher training annually, when the personal care aide has been employed by the school district for three (3) years and has completed 15 hours of in-service training that meets the standards set forth in this section.

- The school district shall have written documentation of all orientation and in-service training provided which includes, at a minimum, a report of each personal care aide's training that outlines the dates of all training, trainer's name, topics, number of hours and location, the date of the first participant contact and includes the aide's signature. If a school district waives an in-service training, the employee's training record shall contain supportive data for the waiver.

Supervision

The school district must employ an administrative supervisor of the day-to-day delivery of direct PC IEP services that meets the following requirements:

- Be at least 21 years of age
- Be a RN who is currently licensed in Missouri; or have at least a baccalaureate degree; or be a LPN who is currently licensed in Missouri with at least one (1) year of experience with the care of the elderly, or individuals with disabilities or medically-complex conditions; or have at least two (2) years' experience with the care of the elderly, or individuals with disabilities or medically-complex conditions
- Establish, implement, and enforce a policy governing communicable diseases that prohibits contact with participants when the personal care aide has a communicable condition, including colds or flu. Assure that reporting requirements governing communicable diseases, including hepatitis and tuberculosis, as set by the DHSS regulation at **19 CSR 20-20.020**, are carried out
- Monitor the provision of services by the personal care aide to assure that services are being delivered in accordance with the plan of care
- Make an on-site visit at least annually to evaluate each personal care aide's performance and the adequacy of the plan of care, including review of the plan of care with the participant and their family. The personal care aide may or may not be present for this evaluation. A written record of the evaluation shall be maintained in the personnel file of the personal care aide.
- Approve, in advance, all changes to the plan of care based on supervisory on-site visits, information from the personal care aide, or observation by the RN, or a combination of these, as noted and dated in the participant's file
- Assist in orientation and personal care training for personal care aides

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- If the supervisor is not a RN, the school district must have a designated RN currently licensed in Missouri either on staff or employed as a consultant. The RN's responsibilities shall include to initial and review all on-site visit reports made by the administrative supervisor. If supervised by a RN, a LPN or GN may perform the RN supervisory activities described in this section.

Direct services provided as documented in a IEP are reimbursed on a cost basis at the Federal Financial Participation (FFP) rate. The remainder of the cost is the responsibility of the school district originating the IEP. Claims for all services are to be billed, and interim payments at the FFP rate will be made based on the MHD maximum allowable rate. Direct services are then cost settled in accordance with the **School-Based IEP Direct Services Cost Settlement Manual**. The MHD maximum allowable fee for each code can be found on the **Fee Schedule**.

All services included in the school-based PC IEP program must be billed by the school district. The school district will be considered the billing provider.

The child receiving school-based PC IEP services must be eligible for MO HealthNet coverage for each date a service is rendered for reimbursement to be made. The child must be under the age of 21. All services rendered to a child must be billed under the child's individual MO HealthNet identification number.

The school district and the personal care provider must maintain a copy of the official public school generated IEP and the plan of care in the child's record to document the service as an IEP service.

Children enrolled in a MO HealthNet managed care plan receive school-based services that are identifiable in an IEP on a fee-for-service basis outside the MO HealthNet managed care benefit package. For more information about MO HealthNet's Managed Care program, please reference **Section 2.16** of this manual.

Provider Enrollment

Each school district interested in billing MHD for school-based PC IEP services must enroll as a MO HealthNet provider. For all enrollment information, go to **MMAC Provider Enrollment website**.

School districts currently enrolled to provide school-based services who wish to expand to include PC IEP services must contact the MMAC Provider Enrollment Unit to request the PC IEP service be added to the school district's enrollment file. This request can be emailed to **MMAC.ProviderEnrollment@dss.mo.gov**; faxed to (573) 526-2054 or mailed to:

Missouri Medicaid Audit and Compliance
Attn: Provider Enrollment Unit
PO Box 6500
Jefferson City, MO 65102-6500

If a school district contracts with a personal care agency to provide PC IEP services, the personal care agency must individually enroll with MO HealthNet and meet the requirements outlined in **13 CSR 70-91**.

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Information provided on the enrollment application must match the information on file with DESE.

Plan of Care

Services are considered school-based when they are included in an IEP as defined by the Individuals with Disabilities Education Act, Part B (34 CFR 300 and 301). In addition to the IEP, a plan of care must be developed and signed by a RN and approved by a physician for a child receiving school-based PC IEP services. Services must be provided as indicated in the IEP and plan of care. A child's plan of care must be evaluated at regular intervals.

The plan of care must specify:

- The diagnosis
- The desired outcome
- The nature of the treatment
- The frequency of treatment (number of minutes per day/per week/per month)
- The duration (weeks or months) of services

The child or their family may not be charged for development of the plan of care. MHD does not reimburse the school district or personal care providers to participate in IEP meetings or when developing a plan of care for a child.

A provider signed plan of care must be maintained at the facility where services are performed and must be made available for audit purposes at any time. MHD does not dictate a standardized plan of care.

The child's treatment record must also include all components, including adequate documentation as required in 13 CSR 70-3.030. Refer to Section 2.5 of this manual for more information.

2.15 Personal Care Service Delivery for Persons with Acquired Immunodeficiency Syndrome

The AIDS Waiver provides home and community-based treatment as a cost effective alternative to the institutional care for individuals living with HIV that have a decreased level of function due to their disease. All MO HealthNet-enrolled personal care providers that have completed the AIDS Waiver Program Addendum to the Provider Agreement are eligible to provide AIDS Waiver personal care. Providers may wish to contact the Department of Health and Senior Services, Bureau of HIV, STD, and Hepatitis to indicate interest in receiving referrals for AIDS Waiver personal care. For more information on the AIDS Waiver, please reference the AIDS Waiver Provider Manual.

2.16 Managed Care

Personal care and advanced personal care services are covered through the MO HealthNet Managed Care Program. The participant's inclusion or exclusion from participation in one of the MO HealthNet

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Managed Care plans may be verified via **eMOMED** or by contacting the IVR system at (573) 751-2896.

All services covered by the managed care health plans are billed to and paid by the plan. The health plan provider name and phone number is identified while verifying participant eligibility. The health plan provider must be contacted for approval prior to delivering services.

Services to be provided to a participant on or after the effective date of enrollment in a managed care health plan which were authorized by the state prior to the participant's enrollment with a health plan must be approved by the health plan.

Refer to Section 9 of the **General Sections Manual** for more information on the MO HealthNet Managed Care Program.

2.17 Personal Care Services and Hospice Program

MO HealthNet covers hospice services for MO HealthNet-eligible persons with a terminal condition whose life expectancy is six (6) months or less. The Hospice Program provides palliative care, rather than active treatment. The Hospice Program includes the following services:

- Nursing care provided by or under the supervision of a RN
- Medical social services
- Physician services performed by a doctor of medicine or osteopathy to meet the general medical needs of the participant to the extent that these needs are not met by the attending physician
- Counseling services must be available to both the participant and the family members or other persons caring for the participant at home. Counseling, including dietary counseling, may be provided both for the purpose of training the participant's family member or other caregiver to provide care and for the purpose of helping the participant and those caring for them to adjust to the participant's approaching death bereavement and spiritual counseling.
- All drugs (prescription or over the counter) and biologicals used primarily for pain or symptom control of the terminal illness
- Short-term inpatient care required for pain control, acute or chronic symptom management
- Short-term inpatient respite care (if in a nursing facility, must have 24-hour RN coverage)
- Medical appliances and supplies related to the participant's terminal illness. This includes covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the participant's terminal illness. Medical supplies include those that are part of the written plan of care.
- Room and board in a MO HealthNet-certified nursing facility

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- Home health aide and homemaker services. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the participant such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the participant. Aide services must be provided under the general supervision of a RN. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care
- Physical therapy, occupational therapy, and speech-language services for purposes of symptom control or to enable the participant to maintain ADLs and basic functional skills. Hospice participants are "locked in" to the hospice provider and must receive all of their medical care related to their terminal illness through the hospice provider with a few exceptions. Personal care and home and community-based waiver services are among the exceptions.

When personal care services are required which are beyond the scope of the home health aide and homemaker services covered under the hospice benefit, the state agency case manager may authorize additional services to be provided by a personal care provider. The state case manager must work closely with the hospice provider to develop a personal care service authorization that does not duplicate, but augments, the aide services the hospice must provide.

When authorizing personal care services for a participant who has elected hospice, the case manager should indicate which hospice provider is providing care.

If it is discovered while serving a participant that a hospice provider is also involved and if the referral information does not indicate that the state case manager is aware of the hospice election, the case manager should be notified. Hospice participants are identified while verifying participant eligibility via **eMOMED** or by contacting the IVR system at (573) 751-2896.

Refer to the **Hospice Provider Manual** for more information.

2.18 Provider Reassessments

HCBS providers have the option to partner with DSDS to gather the necessary information in order for DSDS to determine continued eligibility for HCBS. If a provider chooses not to participate in the reassessment and care planning process, DSDS will reassess the participant.

If a provider chooses to assist with the reassessment of participants the following criteria must be met:

- HCBS providers must complete a **reassessment packet** with MMAC and must have been approved by MMAC as a reassessment provider in order to complete and bill for the completed reassessments.

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- Each month, a list of participants requiring reassessment is sent by DSDS to each provider through SharePoint. Providers must only complete and bill for reassessments of participants that are included in the lists provided by DSDS. Reassessments completed by qualified providers may only be billed for participants when appearing on the list provided by DSDS. Providers may bill only once for these reassessments.
- A provider must ensure that all reassessments are completed by:
    - Provider staff that have either attended the DSDS sponsored train the trainer classes and passed the test; or
    - Provider-qualified staff that has been trained by an individual who has attended and passed the train the trainer class. A list of all individuals who have passed the train the trainer test is maintained on the **DHSS website**.
- Providers must maintain all appropriate documentation to verify that the reassessment was completed. This documentation should indicate on what date the reassessment was completed and what provider staff member completed the reassessment.
- Documentation of the reassessment training must be kept in the personnel file of the individual completing the reassessment if the staff member completing the reassessment is not listed on the DSDS-maintained trainer list. Documentation within the personnel file must include the name of the individual who provided the training and the date that the training occurred.

Section 3 - Special Documentation Requirements

3.1 Requirements

All services covered by the Title XIX Medicaid Personal Care Program must be prior authorized by a Missouri State Agency, or its designee. The specific state agency responsible for authorizing any given personal care service is dependent upon the MO HealthNet Program under which the participant is potentially eligible to receive services.

If personal care is to be provided to an individual that is elderly or 18 years of age or older that has a disability, the authorizing state agency is DHSS/DSDS. If a participant has been diagnosed with Acquired Immunodeficiency Syndrome (AIDS) or a Human Immunodeficiency Virus (HIV)-related illness, their care may be managed and authorized through care coordinators for HIV/AIDS services through DHSS/BHSH. For more information regarding those participants receiving services through the AIDS Waiver, please refer to the **AIDS Waiver Provider Manual**. For children under 21 years of age, the involved state agency is DHSS/BSHCN. Clients may not always clearly fall under any one of the described state agencies case management programs; however, this basic information is provided as a guide.

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Each state agency utilizes assessment and authorization processes unique to their program. All services authorized by DSDS or its designee are authorized utilizing the Home and Community Based Services (HCBS) Web Tool, a component of the MO HealthNet CyberAccess[sm] system. HCBS providers can receive Web Tool guidance by reviewing the **HCBS Web Tool Instructional Guide**.

The provider must access a participant's plan of care from the Participant Case Summary screen in the HCBS Web Tool. This screen provides specific information pertaining to the participant's case. The Case Items section of this screen gives a listing of case stages and a view of the HCBS prior authorizations. The case line will display the 'Prior Authorization (PA) – Care Plan'.

NOTE: A 'Posted' status indicates that a prior authorization number (PA#) has been submitted to Medicaid Management Information System (MMIS). A PA# in 'Pending' status does not ensure payment for any services delivered.

Each posted 'Prior Authorization – Care Plan' will have a specific number assigned to aid in identification. To view the specific services and associated provider(s) authorized for the participant, expand the selected 'Prior Authorization – Care Plan'. This view includes the following information: HCBS authorized; period of time covered by the authorization; the total units per month; and the PA# assigned to the service. Expanding each individual HCBS line provides display of the service tasks (if applicable) and the service frequency. A print icon to the left of the 'Prior Authorization – Care Plan' is available when a paper copy of the plan of care is required.

The effective date for the authorization cannot precede the completion date of the assessment. The end date for the authorization shall not exceed the last full month within 365 days from the completion date of the assessment.

The provider should be aware that if a participant loses MO HealthNet eligibility or coverage during an authorized period of time, services are not reimbursed for the ineligible dates, the posted prior authorization notwithstanding. Refer to the **General Sections Manual** for details about participant eligibility.

Providers should make sure that the participant's name and identification number on the authorization match the participant's MO HealthNet ID card, and that the 'Prior Authorization – Care Plan Services' screen (refer to **Section 3.8** of this manual) contains the provider's correct name for the service to be provided. If any of these items are incorrect, the provider should immediately contact DHSS or its designee to initiate a correction.

In addition to the 'Prior Authorization – Care Plan Services' screen, the provider has access to scanned documents (e.g., Participant Choice Statement) in addition to Case Notes within the participant's electronic health record by navigating to the Case Activity Screen.

Additionally, the provider has access to the following information in the participant's electronic health record.

- PreScreen (read only)
- Assessment Screen

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All documents become a part of the fiscal and medical records, which must be retained to document services billed to the MO HealthNet Division (MHD). Any document used to bill MHD for services rendered (e.g., plan of care/authorization, documentation of services delivered, etc.), must be retained and available for inspection. Refer to the **General Sections Manual** for further information on retention of records requirements.

3.2 Provider Supervisory Monitoring

Supervisors are required to monitor the provision of services by the personal care aide to ensure that services are being delivered in accordance with the personal care plan. This should be primarily in the form of an at least monthly review and comparison of the service participant/aide's log of provided services with the personal care plan. Documentation, including the reason, must be kept on authorized services and units not delivered.

3.3 Requesting Prior Authorization for Personal Care Services for Children

A personal care provider may receive a referral from a hospital discharge planner, a family member, a physician, or other source, requesting personal care on behalf of a child. The personal care provider must take the following steps to request approval for service delivery to a child:

- A plan of care must be developed listing the duties of the personal care aide, duties of the nurse (if required) and the duration and frequency of the visits. This may be done by the provider agency's registered nurse (RN). An example of a plan of care is found in **Section 3.5** of this manual. The provider may photo copy and use the example, or develop their own, as long as it contains sufficient information specifying the amount of personal care and tasks to be performed.
- Physician approval, which documents the child's medical condition and the need for personal care services, must be obtained. Physicians may approve personal care services by:
    - Signing the completed **Prior Authorization Request**
    - Writing an order or prescription for personal care, specifying the medical condition requiring the care
    - Signing a photocopy of the **Physician Certification**, which should contain information verifying the medical diagnosis and the personal care plan. Refer to **Section 3.4** of this manual for more information.
    - Signing a plan of care, or another form similar to the format suggested in **Section 3.5** of this manual.

A **Prior Authorization Request** must be completed and sent to the BSHCN office serving the county of the child's residence. General instructions for completing the form are found on the back

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of the form. The following are detailed instructions for specific fields when requesting personal care services for children:

Section II	**HCY (EPSDT) Service Request**	Completion of this section is at the option of the provider requesting services. The date the child was seen by the physician ordering the personal care service may suffice as the date of the HCY screen, entered in Field 11.
Section III	**Service Information**	
	Field 18	Procedure Code: See Section 5 of this manual.
	Field 21	Enter the date services will terminate if authorization is approved (mm/dd/yy). This date is the end of that month. For example, if services are requested to begin January 15, the end date must be January 31. Up to six (6) months of service may be requested per form, one (1) month on each line.
	Field 23	Enter the total number of units for the month requested in Field 23. Services for children provided through the HCY Program may exceed the limits of the State Plan. Therefore, children are not subject to a cap on the number of units received in one (1) month. The number of units requested must be directly linked to the medical need of the child, and supported by the plan of care and the physician's orders.
	Field 24	If there is a separate attachment containing the description of the medical condition with the physician's authorization, no entry is needed in this field.
Section IV	**Provider**	A signature is not required; however, if BSHCN has questions regarding the request, entry of the name of the contact person within the agency is helpful in this field.
Section V	**Prescribing / Performing Practitioner**	If attaching a copy of the physician approval for the personal care service as described above, completion of this section is not necessary. If physician's orders are not supplied as a separate attachment, then the prescribing physician's signature must be obtained on the form.

BSHCN approves or denies the request for prior authorization of services. **Prior Authorization Requests** for in-home services for children must be sent to the BSHCN office serving the county of

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the child's residence. Reference the **BSHCN Regional Map** for a directory of BSHCN office locations.

The **Prior Authorization Request** is forwarded by BSHCN to the fiscal agent for processing. The fiscal agent returns a Missouri Medicaid Authorization Determination to the provider. The Missouri Medicaid Authorization Determination serves as notification to providers of approvals or denials.

Reauthorizations

Reauthorization requests should be submitted to BSHCN during the last month of the current authorization period, to allow time for review and approval. Follow the same steps as listed above to request reauthorizations.

The reauthorizations should document progress or changes in the child's medical needs. The documentation should support the continuation of service, or explain why changes in level of service are planned.

3.4 Physician Certification of Need for Personal Care Services for Children Under the Age of 21

The Physician Certification is not a standard form. The **Physician Certification of Need for Personal Care Services** may be used as is, or the provider may use another format, such as the physician signature on the Individualized Treatment Plan (ITP). Whichever format is used, it must contain sufficient information about the services required and the physician's signature and date.

Requesting a Change to an Approved Prior Authorization

If the personal care provider agency determines that it is necessary to request a change to an approved Prior Authorization Request, agency staff must submit this request through BSHCN.

3.5 Personal Care Plan for Children

The Personal Care Plan for Children is not a standard form. The **Personal Care Plan for Children** may be used as is, or the provider may develop their own form as long as it contains sufficient information about the services required and the physician's signature and date.

3.6 Home and Community-Based Services Referral

Referrals for HCBS can be made to DSDS, or its designee, by utilizing the **Home and Community Based Services Referral** (HCBS-1). The HCBS-1 is designed to provide DSDS with information to verify prescreen eligibility and determine probable service needs. Providers and professional community partners are encouraged to submit the HCBS-1 by email to **HCBSCallCenterReferrals@health.mo.gov**. Potential participants, or their representatives, are encouraged to contact the HCBS Call Center toll-free at (866) 835-3505 to complete the intake and prescreen process.

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3.7 Home and Community-Based Services Person-Centered Care Plan and Participant Choice Statement

The **Participant Choice Statement** is used by DSDS and allows documentation of the participant's involvement in determining the plan of care by including the participant's acknowledgment of their:

- Right to participate in the development of the person-centered care plan
- Right to have anyone involved in the development of the person-centered care plan
- Right to choose and receive HCBS or nursing facility care
- Loss of services due to discriminatory behavior regarding service delivery
- Expectations and responsibilities
- Right to choose a qualified home and community-based provider
- Need to notify the DHSS Central Registry Unit (CRU) to report abuse, neglect, or exploitation
- Need to notify the appropriate DSDS **Person Centered Care Planning Team** of any problems concerning service delivery as well as changes in health, formal and informal supports, satisfaction with the services provided, and/or functioning status that might require plan of care adjustment

The **Participant Choice Statement** is completed by DSDS or its designee upon initial assessment and any subsequent assessment. DSDS or its designee reviews the information covered on the form with the participant or their authorized representative and ensures the participant's understanding of the information. The document is retained in the participant's electronic health record in the HCBS WebTool. A copy is provided to the participant.

3.8 Prior Authorization Plan of Care Services

The 'Prior Authorization – Care Plan Services' screen is completed by DSDS or its designee, and is designed to provide information to the participant and provider identifying the specific service(s) to be provided.

The 'Prior Authorization - Care Plan Services' screen is a component of the HCBS Web Tool and can be accessed by the provider. A copy of the initial and all subsequent plans of care are sent to the participant. An initial copy is sent to the physician.

3.9 Authorization of Plan of Care Changes in Home and Community-Based Services Web Tool

When an existing plan of care requires a decrease in authorized services, DSDS staff will enter the effective date of change in the HCBS WebTool as the first day of the first month following the date the change is made. This change applies regardless of whether the need for decrease is identified

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in mid-authorization or at reassessment. This also applies when there is a need for a decrease due to cost cap adjustment.

If there are no changes required to the person-centered care plan upon reassessment, DSDS staff will enter the effective date of change in the HCBS WebTool as the first day of the first month following the date of reassessment.

While all efforts will be made to avoid mid-month plan of care changes as described above, certain circumstances may require the authorization change to be made during the month. In these circumstances, providers shall not bill more units than the higher of the two (2) authorizations for the month, and providers shall not bill for units not delivered. Units billed in excess of the higher of the two (2) authorizations or for services not delivered are subject to recoupment.

DSDS will continue to follow current plan of care protocol when a need for an increase is identified during reassessment or following a request for a plan of care change. This means the effective date may fall during the middle of the month. When this happens, two (2) authorizations are active at the same time for that month. However, one (1) authorization ends on the date prior to the increase and one (1) authorization begins on the date of the increase through the end of that authorization period. Again, providers must not bill more than the total units of the higher of the two (2) plan of care authorizations, and the provider shall not bill for units not delivered. Units billed in excess of the higher of the two (2) authorizations or for services not delivered are subject to recoupment.

Section 4-Billing Instructions

4.1 Electronic Data Interchange

Providers exchanging electronic transactions with the MO HealthNet Division (MHD) should access the **ASC X12 Implementation Guides**, adopted under the Health Insurance Portability and Accountability Act (HIPAA). For Missouri specific information, including connection methods, the biller's responsibilities, forms to be completed prior to submitting electronic information, as well as supplemental information, reference the **X12 Version v5010** and **NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guides**.

4.2 Electronic Claim Submission

Providers may submit claims via **eMOMED**. Providers are required to **register** in eMOMED. Providers are unable to access eMOMED without proper authorization. An authorization is required for each individual user.

The following claim types can be used in online applications: Medical (NSF), Inpatient and Outpatient (UB-04), Dental, Nursing Home and Pharmacy. For convenience, some of the input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

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4.3 Unit of Service

A unit of personal care service is 15 minutes of direct service to the participant, including time spent completing work vouchers and obtaining participant signatures. Time spent for travel, lunch, breaks or administrative activities such as completing other reports or paperwork shall not be included.

Personal care providers (both in-home agency and Consumer-Directed Services (CDS)) may bill up to one (1) full month of service on one (1) detail line of a claim.

When billing each date of service, partial units may be accrued and billed on the first date a whole unit is accrued. For example, a provider delivers care from 10:00 a.m. to 11:40 a.m. on June 1, then provides care from 10:00 a.m. to 12:10 p.m. on June 4. Six (6) units of service are billed for June 1, and nine (9) units of service are billed on June 4. Units of the same type of services may accrue, but units of different types of services may not be combined.

4.4 CMS-1500 Claim Form

The CMS-1500 claim form is always used to bill MO HealthNet for personal care services unless a provider bills those services electronically. Instructions on how to complete the CMS-1500 claim form are on the following pages.

The CMS-1500 claim form should be typed or legibly printed. It may be duplicated if the copy is legible. MO HealthNet claims should be mailed to:

Wipro Infocrossing
P.O. Box 5600
Jefferson City, MO 65102

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two (2) asterisks (**) beside the field number indicate a field is required in specific situations.

Field Number	Field Name	Instructions for Completion
1	Type of Health Insurance Coverage	Show type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed check the Medicare box, if a MO HealthNet claim is being filed check the Medicaid Box and if the patient has both Medicare and MO HealthNet, check both boxes.
1a*	Insured's ID Number	Enter the patient's eight (8)-digit MO HealthNet or MO HealthNet Managed Care ID number (DCN) as shown on the patient's ID card

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2*	Patient's Name	Enter last name, first name, middle initial in that order as it appears on the ID card
3	Patient's Birth Date Sex	Enter month, day, and year of birth. Mark appropriate box
4**	Insured's Name	If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete Fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5	Patient's Address	Enter address and telephone number if available
6**	Patient's Relationship to Insured	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7**	Insured's Address	Enter the primary policyholder's address; enter policyholder's telephone number, if available. If no private insurance is involved, leave blank.
8	Patient Status	Not required
9**	Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. See the **General Sections Manual** for further Third Party Liability (TPL) information.
9a**	Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. See the **General Sections Manual** for further Third Party Liability (TPL) information.
9b**	Reserved for NUCC Use	Leave Blank

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9c**	Reserved for NUCC Use	Leave Blank
9d**	Insurance Plan Name or Program Name	Enter the other insured's insurance plan or program name. If the insurance plan denied payment for the service provided, attach valid denial from the insurance plan. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. See the **General Sections Manual** for further Third Party Liability (TPL) information.
10a-10c**	Is Condition Related to:	If services on the claim are related to patient's employment, auto accident or other accident, mark the appropriate box. If the services are not related to an accident, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. See the **General Sections Manual** for further Third Party Liability (TPL) information.
10d	Claim Codes (Designated by NUCC)	Leave Blank
11**	Insured's Policy or Group Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. See the **General Sections Manual** for further Third Party Liability (TPL) information.
11a**	Insured's Date of Birth, Sex	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will

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		deny. See the **General Sections Manual** for further Third Party Liability (TPL) information.
11b**	Other Claim ID (Designated by NUCC)	Enter the "Other Claim ID." Applicable claim identifiers are designated by the NUCC.
11c**	Insurance Plan Name	Enter the primary policyholder's insurance plan name If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. See the **General Sections Manual** for further Third Party Liability (TPL) information.
11d**	Other Health Plan	Indicate whether the patient has a secondary health insurance plan; if so, complete Fields 9-9d with the secondary insurance information. If no private insurance is involved, leave blank. If the insurance plan denied payment for the service provided, attach valid denial from the insurance plan If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. See the **General Sections Manual** for further TPL information.
12	Patient's Signature	Leave blank
13**	Insured's Signature	This field should be completed only when the participant has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.

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14	Date of Current Illness, Injury, or Pregnancy (LMP)	Leave blank
15	Date Same/Similar Illness	Leave blank
16	Dates Patient Unable to Work	Leave blank
17**	Name of Referring Provider or Other Source	Enter the name of the referring provider or other source. If multiple providers are involved, enter one (1) provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider
17a**	Other ID #	Enter the Provider Taxonomy qualifier ZZ in the first shaded area if the provider reported in Field 17b is required to report a Provider Taxonomy Code to MO HealthNet. Enter the corresponding 10-digit Provider Taxonomy Code in the second shaded area for the provider reported in Field 17b.
17b**	NPI	Enter the National Provider Identifier (NPI) of referring, ordering, or supervising provider
18	Hospitalization Dates	Leave blank
19	Reserved for Local Use	Providers may use this field for additional remarks/descriptions
20	Lab Work Performed Outside Office	Leave blank
21*	Diagnosis	Enter the complete current International Classification of Diseases-Clinical Modification (ICD-CM) diagnosis code(s). Enter the primary diagnosis under No. 1, the secondary diagnosis under No. 2, etc.
22**	MO HealthNet Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim under original Ref. NO. or attach a copy of the original Remittance

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		Advice indicating the claim was initially submitted timely.
23	Prior Authorization Number	Leave blank
24a*	Date of Service	Enter the date of service under "from" in month/day/year format, using six (6)-digit format in the unshaded area of the field. All line items must have a from date. The six (6) services lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the service lines are shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.
24b*	Place of Service	Enter the appropriate place of service code in the unshaded area of the field. For personal care, enter 12 (Home)
24c	EMG-Emergency	Leave blank
24d*	Procedure Code	Enter the appropriate Current Procedure Terminology (CPT) code or Health Care Procedure Coding System (HCPCS) code and applicable modifier(s), if any, corresponding to the service rendered in the unshaded area of the field. (Field 19 may be used for remarks or descriptions.) See **Section 5** of this manual for applicable procedure codes.
24e*	Diagnosis Pointer	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from Field 21 in the unshaded area of the field
24f*	Charges	Enter the provider's usual and customary charge for each line item in the unshaded area of the field. This should be the total charge if multiple days or units are shown.

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24g*	Days or Units	Enter the number of days or units of service provided for each detail line in the unshaded area of the field. The system automatically populates a "1" if the field is left blank. A unit of service equals 15 minutes.
24h**	EPSDT/Family Planning	Enter the following depending on the service: • HCY screening service or referral, enter "E" • Family planning related, enter "F" Both HCY and Family Planning, enter "B"
24i**	ID Qualifier	Enter the Provider Taxonomy qualifier ZZ in the shaded area if the rendering provider is required to report a Provider Taxonomy Code to MO HealthNet. A provider taxonomy code must be reported if providers have one (1) NPI for multiple legacy MO HealthNet provider numbers.
24j**	Rendering Provider ID	If the Provider Taxonomy qualifier was reported in 24i, enter the corresponding 10-digit Provider Taxonomy Code in the shaded area. Enter the 10-digit NPI number of the individual rendering the service in the unshaded area.
25	SS #/Federal Tax ID	Leave blank
26	Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here
27	Assignment	Not required on MO HealthNet claims
28*	Total Charge	Enter the sum of the line item charges
29	Amount Paid	Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing and copay amounts are not to be entered in this field.
30	Balance Due	Enter the difference between the total charge (Field 28) and the insurance amount paid (Field 29)

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31	Signature of Physician or Supplier	Not required
32**	Name and Address of Facility	If services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office. Personal care services are in place of service 12 (Home).
32a**	NPI#	Enter the 10-digit NPI number of the service facility location reported in Field 32
32b**	Other ID#	Enter the Provider Taxonomy qualifier ZZ and corresponding 10-digit Provider Taxonomy code for NPI reported in field 32a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and code. A provider taxonomy code must be reported if providers have one NPI for multiple legacy MO HealthNet provider numbers.
33*	Provider Name/Number/Address	Enter the provider's name, phone number and address
33a**	NPI#	Enter the NPI number of the billing provider in Field 33
33b**	Other ID#	Enter Provider Taxonomy qualifier ZZ and corresponding 10-digit Provider Taxonomy code for the NPI reported in Field 33a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and code.

* These fields are mandatory on all CMS-1500 claim forms.

** These fields are mandatory only in specific situations, as described.

4.5 Resubmission of Claims

Any line item on a claim that resulted in a zero payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny must be corrected before resubmitting the claim. The provider may resubmit via **eMOMED** or on a CMS-1500 claim form.

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In certain situations, providers may receive an underpayment on a submitted claim. In these situations, refer to the General Sections Manual rather than resubmitting the claim. When a claim is paid, whether in full or in part, the resubmission of the claim may result in its denial as a duplicate. In cases where the whole claim (zero payment) has been previously denied, the provider may then resubmit with the appropriate corrections. The above applies to overpayments as well. See the General Sections Manual for specific information regarding adjustments.

4.6 Place of Service Codes

Code	Description	Definition
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence

4.7 Insurance Coverage Codes

Type of insurance coverage codes identified on eMOMED, by contacting the Interactive Voice Response (IVR) system at (573) 751-2896, or eligibility files accessed online are listed in Section 5.3 of the General Sections Manual.

While providers are verifying the patient's eligibility, they can obtain the Third Party Liability (TPL) information contained on the MO HealthNet participant file.

Participants must always be asked if they have third party insurance regardless of the TPL information given by eMOMED or the IVR system. It is the provider's responsibility to obtain from the patient the name and address of the insurance company, the policy number, and the type of coverage. Refer to Section 5 of the General Sections Manual for more information on TPL.

4.8 Diagnosis Codes

The diagnosis code must be entered on the claim form exactly as it appears in the applicable International Classification of Diseases-Clinical Modification (ICD-CM). The appropriate code(s) may be up to seven (7) digits, depending upon the patient's diagnosis and applicable ICD code version.

Section 5 – Procedure Codes

Procedure codes used by the MO HealthNet Division (MHD) are identified as Health Care Procedure Coding System (HCPCS) codes. The HCPCS is divided into three subsystems, referred to as Level I, Level II and Level III.

- Level I is comprised of Current Procedural Terminology (CPT) codes that are used to identify medical services and procedures furnished by physicians and other health care professionals.
- Level II is comprised of the HCPCS National Level II codes that are used primarily to identify products, supplies and services not included in the CPT codes.

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- Level III codes have been developed by Medicaid State agencies for use in specific programs.

NOTE: Replacement of Level III codes is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Providers should reference **MHD Bulletins** for code replacement information.

Reference materials regarding HCPCS CPT may be obtained through the **American Medical Association**.

This section lists the appropriate procedure codes for the billing of personal care services. The only acceptable place of service (POS) is 12 (Home). The licensed Residential Care Facility (RCF)/Assisted Living Facility (ALF) is considered the participant's home for the purpose of providing MO HealthNet personal care; therefore, the POS code for services delivered in a RCF/ALF is also 12.

Services Authorized by Division of Senior and Disability Services

The following codes are for services authorized by the Division of Senior and Disability Services (DSDS).

Procedure Code	Description	Service Unit
T1001	Authorized Nurse Visit	Per visit
T1001 U3	Authorized Nurse Visit in RCF/ALF	Per visit
T1019	Personal Care	15 minutes
T1019 TF	Advanced Personal Care	15 minutes
T1019 U2	CDS Personal Care	15 minutes
T1019 U3	Personal Care in RCF/ALF	15 minutes
T1019 U3TF	Advanced Personal Care in RCF/ALF	15 minutes
T1028 TS	Participant Reassessments	One per year*

*Reassessments are done by the provider upon notification of a list provided by DSDS.

Services Authorized by Bureau of Special Health Care Needs - Children

The following codes are valid only for MO HealthNet participants aged 0-20 years, for services under the HCY Program.

Procedure Code	Description	Service Unit
T1001 EP	Authorized Nurse Visit	Per visit
T1019 EP	Personal Care	15 minutes
T1019 TFEP	Advanced Personal Care	15 minutes

The following code requires no prior authorization and is restricted to participants under the age of 21. Two (2) visits may be billed per participant, per agency, per rolling year.

Procedure Code	Description	Service Unit

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T1001 TDEP	Registered Nurse (RN) Evaluation Visit for Personal Care through HCY	Per visit

A rolling year is client-specific. For example, if a client's first date of service is April 15, 2022, then two (2) evaluation visits could be billed between April 15, 2022 and April 14, 2023 by one (1) provider.

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