PERSONAL CARE AGENCY SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirement.

Personal Care Agencies must meet additional Department of Human Services Division of Long-Term Services and Supports (LTSS) requirements which include:

- Undergoing an onsite review and successfully completing any corrective actions necessary.
- Signing a Purchase of Services Agreement between LTSS and the provider.

Providers must also set up an account in LTSS' case management system, Therap, to receive and acknowledge referrals for personal care services.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.

Refer to the Participant Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles
Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Needs Assessment
In order for a recipient to receive personal care services, the recipient must participate in a needs assessment at least once every twelve months. New applicants seeking personal services must demonstrate a need for services by meeting, at a minimum, the following requirements:

- If the recipient's age is less than 60, they must require the assistance of another person to complete at least two Activities of Daily Living, or
- If the recipient's age is 60 or more, they must require assistance of another person to complete any combination of three or more Activities of Daily Living and/or Instrumental Activities of Daily Living; or
- the recipient requires monthly, or more frequent, nursing services ordered by a physician to prevent institutionalization or hospitalization. Note: Recipients that meet these criteria are only eligible to receive the nursing services ordered by the physician. Wound care supplies and/or a medication management device to store the medications safely can be authorized if needed by the nurse to provide the ordered service(s)

Effective July 1, 2024, the above criteria will also be applied to recipients with ongoing personal care services. Those that do not meet the criteria will be discontinued from personal care services.

The needs assessment is conducted by the Department of Human Services, Division of Long Term Services and Supports (LTSS). The needs assessment is based on information provided by the recipient and may encompass the following areas:

- Social resources.
- Physical environment.
- Physical health; and
- Activities of daily living.

LTSS encourages providers to review SDCL Ch. 36-9 to determine when authorized services must be delivered by a licensed nurse.

Service Plan
LTSS develops a service plan for each recipient eligible for personal care services. The plan is based on the recipient's needs assessment and contains items such as the following:

- The reason for the service request;
- The number of personal care service hours assigned to the recipient
- The personal care services needed; and
- The recipient's responsibilities.

Covered Personal Care Services
Personal care services are limited to medically necessary services contained in the recipient's service plan and provided in a home or community-based location.

Personal care services covered are limited to the following:

- Basic personal care and grooming, including bathing, shaving, dressing, and assisting the recipient with hair and teeth care.
- Assistance with bladder or bowel requirements, which does not include administration of a bowel program;
- Assisting the patient with medications which are ordinarily self-administered;
- Assistance with food, nutrition, and diet activities if they are incidental to a medical need;
- Performing those household services, if related to a medical need, that are essential to the patient's health and comfort in the patient's residence; or
- Maintenance nursing prescribed by a physician.

A home or community-based location does not include a hospital, penal institution, detention center, school, nursing facility, assisted living center, congregate facility where services are available, other types of group settings, intermediate care facility for individuals with intellectual disabilities, or an institution which treats individuals for mental diseases.

Hours Limitation

A recipient is limited to 500 hours of agency based personal care services in a plan year (July 1 – June 30). This limit does not apply to recipient's age 20 or younger. If a recipient is eligible for a home and community-based services waiver and has an assessed need for more than 500 hours, additional units may be authorized under the applicable waiver program.

Discontinuance and Denial of Services

The department may discontinue or deny personal care services when the department exhausts its resources for providing the services, the recipient can no longer benefit from the services provided, or the recipient's or the provider's health or safety would be jeopardized if the services were continued. Specific reasons for discontinuing or denying services include the following:

- The recipient does not meet eligibility requirements.
- The recipient failed to cooperate with the needs assessment.
- The recipient is sexually harassing, verbally abusive, threatening, or combative.
- The recipient's personal care plan service needs exceed the service limits of the program.
- The recipient's physical environment presents health and fire hazards or unsafe conditions.
- The recipient is not in compliance with the case service plan.
- The provider must have a policy for discharge of recipients that are determined ineligible, or the provider can no longer serve. When a provider determines services to a critical needs recipient must be discontinued by their agency, the provider must notify LTSS at least 30 days before the recipient is discharged. If the recipient is a critical service needs recipient, the provider must provide a written discharge notice at least 30 days before the recipient is discharged
- If the recipient's home constitutes an unsafe environment for provider's staff and/or the recipient is demonstrating unsafe behaviors toward agency staff, resulting in intent to discharge, the provider must provide a written discharge notice upon the determination to discharge. The discharge notice must be in writing, identify the last day services will be rendered by the provider, and specify the reason for discharge in accordance with the provider's discharge

policy. The provider must provide a copy of the discharge notice to both the recipient and the State.

NON-COVERED SERVICES

General Non-Covered Services
Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Personal care services cannot be provided by a recipient's legally responsible person. A legally responsible person includes parents of minor children or a spouse.

DOCUMENTATION REQUIREMENTS

General Requirements
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

Electronic Visit Verification (EVV) Requirements
Personal Care Services must comply with federal Electronic Visit Verification (EVV) requirements. Providers should refer to the Electronic Visit Verification Manual for additional information.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement
Payment for services will be the lower of the provider's usual and customary charge or the rate listed on the Personal Care Agency fee schedule.

Claim Instructions
Services must be billed on a CMS 1500 claim form or via an 837P electronic transaction. Refer to the website for detailed billing instructions.

HCPCS
Services should be billed for using the applicable HCPCS code list below:

- S5130 – Homemaker services
- T1019 – Personal care services
- T1000 – Maintenance nursing

DEFINITIONS

1. "Activities of daily living," tasks performed routinely by a person to maintain physical functioning and personal care, including transferring, moving about, dressing, grooming, toileting, and eating;

2. “Instrumental activities of daily living (IADLs),” activities that reflect an individual's ability to live independently, including managing money, using transportation, shopping for food and household items, housekeeping, and preparing meals;

3. "Maintenance nursing," periodic evaluation and counseling by a licensed nurse to promote and maintain the individual’s optimal health. Maintenance nursing may include injections, monitoring and setting up medications, physical assessments, monitoring patient status, foot care, drawing blood, changing dressing, and health education;

4. "Personal adjustment," the mental or emotional state of well-being of a recipient on a continuum from good to poor. Poor personal adjustment may include problems with sleeping, difficulty in expressing feelings, unhappiness, or depression;

5. "Personal care provider," an agency incorporated in South Dakota which has a contract with the department to provide personal care services in the recipients place of residence;

6. "Personal care services," medically necessary services in the recipient's case service plan described in ARSD 67:16:24:03.03 that are provided by an individual who is qualified to provide the services and is not a member of the recipient's family;

7. "Physical environment," the recipient's dwelling unit, building, or house and its furnishings and the neighborhood in which the recipient resides;

8. "Physical health," the medical state of well-being which may be on a continuum from good to poor. Poor health is the presence of one or more illnesses or physical disabilities which are either painful or inhibit a person's ability to perform daily tasks; and

9. "Social resources," support or assistance available to a recipient from the recipient's family, friends, neighbors, or community organizations such as churches, civic groups, or senior centers or other agencies providing services to residents of the community.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **What happens if the recipient has reached the 500-hour limit and still needs services?**

   The provider and/or recipient may contact Dakota at Home at 1-833-663-9673 to determine if additional services may be authorized.

2. **Can an individual on the CHOICES or Family Support 360 waiver receive personal care services through this program?**

   An individual on the CHOICES or Family Support waivers may receive Personal Care Services if it is deemed appropriate by the Waiver Operations staff within the Division of Development Disabilities. Referrals should be made through Dakota at Home.

3. **What is the difference between Personal Care Services and the HOPE Waiver?**
   Personal Care Services are available to recipients eligible for Medicaid who have a medical necessity for the services. The services are limited to homemaker, personal care, and nursing and are capped at 500 hours per fiscal year. The HOPE Waiver providers a broader array of home and community-based services to adults who are disabled, or who are age 65 or older who meet the nursing facility level of care defined in the waiver. Services for both programs are based on assessed need and identified in a person-centered service plan.

4. **Is maintenance nursing subject to EVV requirements?**

   Yes, maintenance nursing provided though the personal care services benefit is subject to EVV Verification Requirements.

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