

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 7, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2600 – INTERMEDIARY SERVICE ORGANIZATION
(ISO)

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2600 are being proposed to differentiate and separate policy for the two services that can be self-directed through an ISO; Self-Directed Personal Care Services (SD PCS) and Self-Directed Skilled Services. SD PCS policy is being aligned with current Personal Care Services (PCS) policy in MSM Chapter 3500 and several new sections were added for this purpose. Some sections were combined and/or merged together to create a new section or deleted to remove repetition. Language was moved from some sections and added to others where more appropriate. All licensure requirements have been removed from policy, as oversight for such is the responsibility of the licensing agency. In addition, outdated language and procedures were removed and replaced with current language and procedures where applicable. Overall updates were made to ensure PCS policy and requirements are the same regardless of the delivery model.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: None.

Financial Impact on Local Government: None.

These changes are effective September 8, 2016

MATERIAL TRANSMITTED

CL 30118
CHAPTER 2600 – INTERMEDIARY
SERVICE ORGANIZATION (ISO)

MATERIAL SUPERSEDED

MTL 11/12, 37/11,
CHAPTER 2600 – INTERMEDIARY
SERVICE ORGANIZATION (ISO)

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2600	Introduction	Updated language to include the two services allowed under Nevada Medicaid’s Self-Directed service delivery model and provided through an ISO: Personal Care Services and Skilled Services.
2601	Authority	Section condensed. Deleted Social Security Act definition of PCS along with NRS and Nevada State Plan references. Added list of regulatory oversight.
2602	Reserved	Section renamed “Definitions” and added reference to MSM Addendum for program definitions.
2603	Policy	Section condensed to be an introduction to the two services that can be self-directed through an ISO. Language removed has been incorporated in different sections throughout the chapter where appropriate. Legally Responsible Individual (LRI) language incorporated into new Section 2603.2.
2603.1	Self-Directed (SD) Model	Section renamed “Self-Directed Personal Care Services (PCS)”; added language on type of assistance provided under Self-Directed PCS and clarified other existing language. Subsections 2603.1(a) moved to 2603.1B and 2603.1(b) was deleted and its language incorporated throughout the chapter where appropriate.
2603.1A	Program Eligibility Criteria	Moved from 2603.1A.2 to current Section and renamed “Eligibility Criteria.” Additional criteria added to be in line with policy in MSM Chapter 3500. Coverage and Limitations now in 2603.1C.
2603.1B	Self-Directed Model Initiation	Moved from 2603.1(a) to current section and renamed “Initiating Self-Directed Personal Care Services (SD PCS).” Updated language and reworded for clarity, removed reference to obsolete NMO forms. Provider Responsibility now in 2603.8.
2603.1C	Coverage and Limitations	Previously in 2603.1A. Moved to current section and renumbered. Added new subsections for covered services, service limitations and non-covered services to be in line with policy in MSM Chapter 3500. Recipient/Personal Care Representative (PCR) Responsibilities now in 2603.9.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2603.1D	Authorization Process	Removed reference to MSM Section 3503.1E. Added current PCS authorization procedures to be in line with policy in MSN Chapter 3500.
2603.1 E	Flexibility of Service Delivery	New section added to align with policy in MSM Chapter 3500. Section specifies flexibility of service delivery for recipients.
2603.1F	Conflict of Interest Standards	New section added to align with policy in MSM Chapter 3500. Section specifies conflict of interest standards for providers completing the functional assessment service plan.
2603.2	Legally Responsible Individual (LRI)	LRI language previously in Section 2603 now in current section. This new section specifies LRI policy and requirements for LRIs that are not available and for those not capable of providing care. SD Skilled Services Sections previously in 2603.2 moved and now start in Section 2603.7.
2603.3	Personal Care Representative (PCR)	Previously Section 2603.1A (1). Section language was updated to align with policy in MSM Chapter 3500. PCS IC Model sections previously in 2603.3 moved and now start in Section 2604.
2603.4	Services to Children	New section added to align with policy in MSM Chapter 3500. Section includes policy applicable to children receiving services to align with policy in MSM Chapter 3500. Escort Services Section previously in 2603.4 now starts in Section 2603.10.
2603.5	PCS for Recipients Enrolled in Hospice	New section added to align with policy in MSM Chapter 3500. Section specifies policy for recipients also enrolled in hospice. Transportation Section previously in 2603.5 now in Section 2603.11.
2603.6	Residential Support Services / Supported Living Arrangement (SLA)	New section added to align with policy in MSM Chapter 3500. Section specifies policy for recipients receiving residential supports through SLAs. Quality Assurance Section previously in 2603.6 now in Section 2603.14.
2603.7	Self-Directed (SD) Skilled Services	Updated language and reworded for clarity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2603.7A	Program Eligibility Criteria	Moved from 2603.2A (1) to current section. Section renumbered and renamed “Eligibility Criteria” and some language was updated.
2603.7B	Self-Directed (SD) Skilled Services Initiation	Moved from 2603.2 (a) to current section. Section renumbered and renamed “Initiating SD Skilled Services”. Updated section to reflect current process for initiating SD Skilled Services.
2603.7C	Coverage and Limitations	Moved from 2603.2A to current section. Section renumbered, program eligibility criteria subsection was moved to 2603.7A and remaining subsections were rearranged to improve readability.
2603.7D	Authorization	Moved from 2603.2D to current section. Section renumbered, renamed “Authorization Process” and language was updated to reflect current authorization process for Self-Directed Skilled Services.
2603.8	Provider Responsibility	Moved from 2603.1B to current section. Section was renumbered and renamed “Provider Responsibilities,” language was updated and reworded for clarity for various requirements. Provider enrollment requirements were removed and updated to reflect current process. Licensure requirements, such as criminal background checks, tuberculosis testing and training have been removed from section. Several requirements were removed as they are no longer applicable to the provider type for which this policy is written such as time parameters, 24 hour accessibility and referral source agreement. New requirements were added to reflect current processes. Reference to MSM 3500 sections were removed throughout and replaced with current policy for each requirement to align with PCS provider requirements in MSM Chapter 3500. Provider responsibilities previously in Section 2603.2B and 2603.2B (1) were incorporated in this section.
2603.9	Recipient/Personal Care Representative (PCR) Responsibilities	Moved from 2603.1C to current section. Section was renumbered and renamed “Recipient Responsibilities and Rights.” Section now includes responsibilities previously in 2603.2C applicable to those opting to self-direct their skilled services and a new subsection for recipient rights to align policy with MSM 3500.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2603.10	Escort Services	Moved from 2603.4 to current section. Section renumbered and reference to MSM Section 3503.8 was removed.
2603.10A	Coverage and Limitations	Added new section to align with policy in MSM Chapter 3500. Specifies service conditions.
2603.10B	Authorization Process	Added new section to align with policy in MSM Chapter 3500. Specifies specific authorization process for escort services.
2603.10C	Provider Responsibility	Added new section to align with policy in MSM Chapter 3500. Specifies escort service responsibilities for providers.
2603.11	Transportation	Moved from 2603.5 to current section. Reworded for clarity.
2603.12	Reimbursement	Added new section to align with policy in MSM Chapter 3500. Details some of the costs associated with doing business for which separate reimbursement is not available.
2603.13	Improper Billing Practices	Added new section to align with policy in MSM Chapter 3500. Details some improper billing practices and possible consequences.
2603.14	Quality Assurance	Moved from 2603.6 to current section. Section was reworded and updated to specify current process.
2603.15	Adverse Actions	Added new section to align with policy in MSM Chapter 3500. Specifies when adverse action may be taken by the DHCFP or its designee.
2604	PCS Independent Contractor (IC) Model	Moved from 2603.3 to current section for improved readability and flow. Throughout the section, grammar, punctuation, and capitalization changes were made, acronyms used and standardized, and language reworded for clarity. Provider enrollment requirements were updated to reflect current process. Specific section references were updated throughout to reflect correct section numbers.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2605	Hearings	Moved from 2604 to current section. Updated reference language to include “hearing procedures” and “Medicaid.”
2606	Self-Directed (SD) Skilled Services – Clinical Decision Support Guide	Renumbered from 2605 to 2606.

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DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2600
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

2600 INTRODUCTION

INTERMEDIARY SERVICE ORGANIZATION - (ISO)

An Intermediary Service Organization (ISO) is an entity acting as an intermediary between Medicaid recipients, who elect the Self-Directed (SD) service delivery model, and the Personal Care Assistants (PCAs) who provide those services. In the SD service delivery model, the recipient is the managing employer of the PCA, and the ISO is the employer of record.

Under the SD service delivery model, Nevada Medicaid allows for the self-direction of two services through an ISO, Personal Care Services (PCS) and Skilled Services. These services are provided where appropriate, when medically necessary and within service limitations. Services may be provided in settings outside the home, including employment sites.

SD PCS and Skilled Services are available to recipients, including those persons with cognitive impairments, who have the ability and desire to manage their own care. When a recipient does not have the ability to manage or direct their own care, a Personal Care Representative (PCR) may be selected on the recipient's behalf to direct the services.

SD PCS and SD Skilled Services are available to recipients who are not inpatients or residents of a hospital, Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities or persons with related conditions (ICF/IID), institutions for mental disease or other excluded settings.

This Medicaid Services Manual (MSM), Chapter 2600, contains Nevada Medicaid's policy for the SD service delivery model of PCS and Skilled Services provided through an ISO. For policy pertaining to the Provider Agency service delivery model of PCS, refer to Chapter 3500.

~~Personal care services (PCS) may be provided by any willing and qualified provider through a provider agency utilizing the standard delivery model or through an Intermediary Service Organization (ISO) when accessing the Self Directed (SD) model for services. The ISO acts as an employer of record, providing both fiscal and supportive intermediary services such as administrative, limited program and specific payroll responsibilities for the delivery of personal care services. All providers must be contracted with the Division of Health Care Financing and Policy (DHCFP) in accordance with Chapter 100 and meet certain qualifications and criteria as discussed later in this chapter.~~

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

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MEDICAID SERVICES MANUAL	Subject: AUTHORITY

2601 AUTHORITY

Personal Care Services (PCS) are an optional Medicaid benefit under the Social Security Act. ~~(SSA) 1905(a)(24) and 1902.(10).~~

Regulatory oversight:

- Social Security Act 1902 (10)
- Social Security Act 1905 (a)(24)
- Title 42, Code of Federal Regulations, Section 440.167
- Nevada State Plan Attachment 3.1-A(26)

~~SSA 1905(a)(24) defines PCS as services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are:~~

- ~~a. — authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State;~~
- ~~b. — provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and~~
- ~~c. — furnished in a home or other location.~~

~~Authority under NRS 427A.701 through NRS 427A.745 “Intermediary Service Organization”.~~

~~Authority under the Nevada State Plan can be found in Attachment 3.1-A (26).~~

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2602 **RESERVEDDEFINITIONS**

Program definitions can be found in the Medicaid Services Manual (MSM) Addendum.

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MEDICAID SERVICES MANUAL	Subject: POLICY

2603 POLICY

Nevada Medicaid offers two services that can be self-directed by the recipient or their Personal Care Representative (PCR) through an Intermediary Service Organization (ISO): PCS and Skilled Services.

Legally responsible individuals (LRIs) may not be reimbursed for providing Self-Directed (SD) PCS and/or SD Skilled Services.

~~An Intermediary Service Organization (ISO) is an entity acting as an intermediary between Medicaid recipients, who elect the Self-Directed (SD) Service Delivery Model, and Personal Care Assistants (PCA). ISO services must be provided in a manner that affords individuals and their representative's choice and control over the services they receive and the qualified support service providers who provide them.~~

~~ISO's provide two primary functions. The first function is to reduce and individual's employer related burden through the provision of appropriate fiscal and supportive services. The second function is to assure the state that support services are being provided to an individual in compliance with federal, state and local regulations. An individual who chooses an ISO to facilitate support services must be fully informed of his/her role and responsibilities, the role and responsibilities of the ISO, and must review and sign an agreement with the ISO. The ISO agreement with the recipient is in addition to any required the Division of Health Care Financing and Policy (DHCFP) forms. A copy of the agreement must be given to the DHCFP's care coordination unit. The original must be maintained with the ISO. At a minimum, the agreement must include:~~

- ~~a. role and responsibilities of the individual;~~
- ~~b. role and responsibilities of the ISO;~~
- ~~c. acknowledgement the individual has reviewed the information and understands his/her role and responsibilities related to self directing her/her support services using an ISO;~~
- ~~d. acknowledgement the individual accepts her/her role and responsibilities related to using the chosen ISO; and~~
- ~~e. acknowledgement of choice of ISO agencies.~~

~~Legally Responsible Individuals (LRI) may not be reimbursed for providing Personal Care Services (PCS). The LRI must provide verification to the DHCFP's Quality Improvement Organization (QIO) like vendor, from a physician, place of employment, or school that they are not capable, due to illness or injury, or available, due to hours of employment and school~~

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~~attendance, to provide services. Additional verification may be required on a case by case basis. Without this verification, PCS will not be authorized.~~

~~An ISO employee who has not met all of the requirements of this section is not qualified to provide services to Medicaid recipients. Any ISO that permits an unqualified PCA to provide services to a Medicaid recipient is in violation of the Medicaid provider contract and subject to all actions available, including but not limited to discontinuation of their provider agreement and/or full recoupment of monies paid as discussed in the Medicaid Service Manual (MSM) Section 3503.1E under “Improper Billing Practices”.~~

2603.1 SELF-DIRECTED ~~(SD) MODEL~~ PERSONAL CARE SERVICES (PCS)

Self-Directed PCS provide assistance to support and maintain recipients living independently in their homes. Services may be provided in the home, locations outside the home, or wherever the need for the service occurs. Assistance may be in the form of direct hands-on assistance or cueing the individual to perform the task themselves, and related to the performance of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Services are based on the need of the recipient being served, as determined by a Functional Assessment Service Plan (FASP) approved by the Division of Health Care Financing and Policy (DHCFP). All services must be performed in accordance with the approved service plan and must be prior authorized. The time authorized for services is intended to meet the recipient needs within program limits and guidelines, facilitate effective and efficient service delivery, and to augment unpaid and paid supports currently in place. Services are not intended to replace or substitute services and/or supports currently in place, or to exchange unpaid supports for paid services.

~~The SD Model is a service delivery option which allows the recipient to direct their own personal care. Services under the personal care optional benefit~~ Services are available to recipients in need of PCS, including persons with cognitive impairments, who have the ability and desire to manage their own care. When the recipient does not have the ability to manage ~~or direct~~ their own care, a ~~Personal Care Representative (PCR)~~ may do so on their ~~to direct the provider on the recipient's behalf~~ may be selected.

This option is utilized by accessing services through an ISO. The ISO is the employer of record and the recipient is the managing employer ~~for the PCAs that provide the services.~~

2603.1A ~~PROGRAM~~ ELIGIBILITY CRITERIA

1. The recipient must have ongoing Medicaid or Nevada Check Up (NCU) eligibility for services;
2. The recipient is not in a hospital, Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an institution for the mentally ill or a licensed residential facility for groups;

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3. The recipient does not have a LRI who is available and capable of providing the necessary care;
4. The recipient ~~or the PCR~~ must be ~~capable~~ ~~able~~ ~~of~~ ~~to~~ making choices about ADLs, understand the impact of these choices and assume responsibility for them ~~choices~~ or have a PCR who is willing to assist the recipient in making choices and assumes responsibility for those choices;
5. The recipient or PCR ~~may reside outside the home if frequent contact can be made by the recipient, the ISO, and other care providers. The PCR must be cooperative in establishing available to the need for recipient, the provision of services and comply with the approved service plan; ISO and other care providers as necessary to fulfill the regular elements of Section 2603.1C of this chapter.~~
6. PCS must be determined to be medically necessary as defined by the DHCFP or its designee; and ~~The recipient or PCR must manage specific documentation and verification functions.~~
7. The recipient or PCR must be willing and capable of managing all tasks related to service delivery including, but is not limited to: recruitment, selection, scheduling, training and directing PCAs.

2603.1B INITIATING SELF-DIRECTED PERSONAL CARE SERVICES (SD PCS) MODEL INITIATION

The recipient, LRI or their PCR indicates interest in self-directing their PCS ~~the SD Model~~ by contacting their local DHCFP District Office or Aging and Disability Services Division (ADSD) District Office directly.

1. The DHCFP District Office or local ADSD District Office staff provides information to the recipient or the PCR about the self-directed services available ~~SD Model~~. If the recipient is interested in self-direction, a list of enrolled Medicaid ISO providers is provided to the recipient to choose and initiate contact with the ISO of his or her choice.
2. If the recipient elects to self-direct his or her own PCS, ~~the ISO will provide and the recipient will sign the Intermediary Service Organization (ISO) Self-Directed Personal Care Services Unskilled Only Recipient Agreement (Form NMO-3434), ISO SD PCS Unskilled Only Recipient Agreement, or if the PCR is directing the recipient's care, the PCR will sign Form NMO-3437, ISO SD.~~
3. If the recipient elects a PCR to direct his or her care, the ISO will provide and the PCR will sign the Intermediary Service Organization (ISO) Self-Directed Personal Care

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~~Services PCS—Unskilled Only Personal Care Representative PCR—Agreement (Form NMO-3437).~~

~~A signed copy of either agreement should be given to the recipient and/or PCR form will be sent to the QIO-like vendor and the ISO shall retain the original for their records.~~

~~4. The ISO forwards Form NMO-3432, ISO Authorization Request to the QIO-like vendor.~~

~~5. The QIO-like vendor authorizes or denies the ISO option.~~

~~6. Reference Section 2603.2 for skilled services.~~

~~Recertification is needed annually or when a significant change in condition or circumstances occurs. Reference MSM Section 3503.1E.1.d for significant change in condition or circumstances criteria.~~

~~b. PCS FUNCTIONAL ASSESSMENT~~

~~All services must be based on the needs of the recipient as determined by a PCS functional assessment. Assistance may be in the form of direct hands on assistance or cueing the individual to perform the task themselves, and related to the performance of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). PCS are not intended to replace or substitute services or supports currently in place, nor exchange paid services for unpaid support.~~

~~PCS may be provided in the home, or locations outside the home, including employment sites, wherever the need for PCS occurs. The time authorized for services is documented in the approved service plan, regardless of the location of services. Time authorized is intended to meet recipient needs within program limits and guidelines, facilitate effective and efficient service delivery, and to augment unpaid and paid supports currently in place.~~

2603.1CA COVERAGE AND LIMITATIONS

~~All policies found in the MSM Section 3503.1A apply, including covered services, service limitations, non-covered services, and adverse actions unless otherwise indicated in this section.~~

~~1. Covered Services~~

~~a. Assistance with the following ADLs is a covered service when no LRI is available and/or capable of providing the necessary service. Services must be directed to the individual recipient and related to their health and welfare.~~

~~1. Bathing/dressing/grooming.~~

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2. Toileting needs and routine care of an incontinent recipient.
3. Transferring and positioning non-ambulatory recipients from one stationary position to another, assisting a recipient out of bed, chair or wheelchair, including adjusting/changing recipient's position in a bed, chair or wheelchair.
4. Mobility/Ambulation, which is the process of moving between locations, including walking or helping the recipient to walk with support of a walker, cane or crutches or assisting a recipient to stand up or get to his/her wheelchair to begin ambulating.
5. Eating, including cutting up food. Specialized feeding techniques may not be used.

b. Assistance with the following IADLs is a covered service when no LRI is available and/or capable of providing the necessary service. Services must be directed to the individual recipient and related to their health and welfare. See the service limitations section of this chapter for specific eligibility criteria to be considered eligible to receive additional time for assistance with IADLs.

1. Meal preparation, which includes storing, preparing and serving food.
2. Laundry, which includes washing, drying and folding the recipient's personal laundry and linens (sheets, towels, etc.). Ironing is not a covered service.
3. Light housekeeping, which includes changing the recipient's bed linens, dusting, or vacuuming the recipient's living area.
4. Essential shopping, which includes shopping for prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and nutrition of the recipient.

2. Service Limitations

To be considered eligible to receive additional time for assistance with IADLs, the recipient must be eligible to receive PCS for ADLs and have deficits which directly preclude the individual from completing IADLs. The FASP must demonstrate that the recipient meets the following criteria:

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- a. The recipient has extensive impairments, Level 2 or higher on the FASP in two or more areas of ADLs; and
- b. The recipient has at least one of the deficits listed below:
 - 1. Mobility deficits/impairments of an extensive nature which requires the use of an assistive device, and directly impacts the recipient's ability to safely perform household tasks or meal preparation independently;
 - 2. Cognitive deficits directly impacting the recipient's ability to safely perform household tasks or meal preparation independently;
 - 3. Endurance deficits directly impacting the recipient's ability to complete a task without experiencing substantial physical stressors; or
 - 4. Sensory deficits directly impacting the recipient's ability to safely perform household tasks or meal preparation independently.

Assistance with the IADLs may only be provided in conjunction with services for ADLs, and only when no LRI is available and/or capable.

3. Non-Covered Services

Duplicative services are not considered medically necessary and will not be covered by Nevada Medicaid. An inquiry or referral for services does not determine the medical necessity for services.

The following are not covered under PCS and are not reimbursable:

- a. A task that the DHCFP or its designee determines could reasonably be performed by the recipient.
- b. Services normally provided by a LRI.
- c. Any tasks not included on the recipient's approved service plan.
- a.d. Services to maintain an entire household, such as cleaning areas of the house not used solely by the recipient(s).
- e. Services provided to someone other than the intended recipient.

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- f. Skilled care services requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or certified by the State. Services include, but are not limited to, the following:
1. Insertion and sterile irrigation of catheters;
 2. Irrigation of any body cavity. This includes both sterile and non-sterile procedures such as ear irrigation, vaginal douches, and enemas;
 3. Application of dressings involving prescription medications and aseptic techniques, including treatment of moderate or severe skin problems;
 4. Administration of injections of fluids into veins, muscles, or skin;
 5. Administration of medication, including, but not limited to, the insertion of rectal suppositories, the application of prescribed skin lotions, or the instillation of prescribed eye drops (as opposed to assisting with self-administered medication);
 6. Physical assessments;
 7. Monitoring vital signs;
 8. Specialized feeding techniques;
 9. Rectal digital stimulation;
 10. Massage;
 11. Specialized range of motion (ROM);
 12. Toenail cutting;
 13. Medical case management, such as accompanying a recipient to a physician's office for the purpose of providing or receiving medical information; and
 14. Any task identified within the Nurse Practice Act as requiring skilled nursing, including Certified Nursing Assistant (CNA) services.
- g. Chore services.
- h. Companion care, baby-sitting, supervision, or social visitation.

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- i. Care of pets except in cases where the animal is a certified service animal.
- j. Respite care intended primarily to relieve a member of the recipient's household, a family member, or caregiver from the responsibility of caring for the recipient.
- k. A task the DHCFP determines is within the scope of services provided to the recipient as part of an assisted living contract, a supported living arrangement contract, or a foster care agreement.
- l. Escort services for social, recreational or leisure activities.
- m. Transportation of the recipient by the PCA.
- n. Any other service not listed under Section 2603.1C.1.

2603.1D

AUTHORIZATION PROCESS

~~The policies discussed in the MSM Section 3503.1E, apply to the SD Model.~~

PCS authorization requests must be submitted to the QIO-like vendor using the following procedures:

1. Initial Authorization Requests

The recipient, LRI, PCR or an individual covered under the confidentiality requirements of Health Insurance Portability and Accountability Act (HIPAA) may contact the QIO-like vendor to request PCS. Initial requests may not be made by the PCS Agency provider.

The QIO-like vendor validates that the recipient meets PCS criteria, and if so, an enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS.

After completion, the FASP is forwarded to the QIO-like vendor to process.

If the recipient's request for PCS is approved, the QIO-like vendor will issue a prior authorization number to the recipient's chosen ISO Provider.

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a. At Risk Recipient Requests

Upon receipt of a request for an initial FASP, the QIO-like vendor will first complete a risk assessment over the phone, to identify those recipients for whom PCS are urgent to avoid institutionalization, or for whom the service need is the result of an acute medical condition or loss of a primary caregiver or LRI. The intent of the telephonic risk assessment is to determine if a recipient is at risk of losing or being unable to return to a community setting because of the need for PCS.

When a recipient is determined “at risk,” the QIO-like vendor will provide a temporary service authorization. An enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient’s functional abilities.

The physical or occupation therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists’ clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient’s need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

The selected ISO Provider is notified when a recipient is at risk and agrees, by accepting the case, to initiate needed services within 24 hours of case acceptance. The approved service plan and authorization document are faxed to the provider upon acceptance.

2. Annual Update Authorization Requests

To prevent a break in service, reassessment requests for ongoing services are recommended to be submitted to the QIO-like vendor at least 60 days but not greater than 90 days prior to the expiration date of the current authorization. The request must be submitted on the Authorization Request for PCS form (FA-24). The form must include all required recipient and provider information, as well as the units requested and the dates of service for the service interval requested.

The QIO-like vendor validates that the request meets PCS criteria. An enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient’s functional abilities.

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The assigned physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

If the request is approved, the QIO-like vendor will issue a prior authorization number to the ISO Provider submitting the request.

3. Significant Change in Condition or Circumstance Authorization Requests

Requests for reassessment due to significant change in the recipient's condition or circumstances must be submitted to the QIO-like vendor as soon as the significant change is known. A request for reassessment due to significant change in the recipient's condition or circumstances must be submitted on the Authorization Request for PCS form (FA-24) and must be accompanied by documentation from the recipient's physician or health care provider. Requesting a reassessment does not guarantee an increase in previously approved PCS.

- a. Significant change in condition may be demonstrated by, for example, an exacerbation of a previous disabling condition resulting in a hospitalization (within past 14 days) or a physician's visit (within past seven days), or a new diagnosis not expected to resolve within eight weeks.
- b. Significant change in circumstances may include such circumstances as absence, illness, or death of the primary caregiver or LRI.
- c. Significant change in condition or circumstances would result in hospitalization or other institutional placement if PCS are not reassessed to meet the recipient's change in service needs.

The QIO-like vendor validates that the request meets PCS criteria and if so, an enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

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Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

If the request is approved, the QIO-like vendor will issue a prior authorization number to the ISO Provider submitting the request.

4. Temporary Service Authorization Requests

When the recipient has an unexpected change in condition or circumstance which requires short-term (less than eight weeks) modification of the current authorization, a new FASP is not required.

Such a modification is considered when additional PCS are required for a short time as the result of an acute medical episode or during a post-hospitalization period.

The following procedure must be followed for all short-term modifications of the approved service plan:

- a. Documentation must be maintained in the recipient's record of the circumstances that required the short term modification(s) of the approved authorization;
- b. Documentation of the short-term modification(s) of the approved service plan must be completed and sent to the ISO, and if applicable the appropriate home and community-based waiver case manager. Documentation must include the recipient's name, Medicaid number, and the dates during which the modified service plan will be in effect; and
- c. Upon expiration of the modified service plan, the recipient's original approved service plan is automatically reinstated unless a new FASP is completed due to a significant change in the recipient's condition or circumstance.

5. One-Time Service Authorization Request

The recipient's Provider Agency may submit a single-service authorization request, when the recipient requires an extra visit for an unanticipated need(s), such as bowel or bladder incontinence. The Provider Agency must document the medical necessity of the services requested and be the designated provider for the current authorization period. The request must be submitted to the QIO-like vendor no later than seven business days after the service is provided. A new FASP is not required in these single-service situations.

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6. Mileage Authorization Request

Mileage for travel to and from a recipient's home or for shopping is not reimbursable to ISO providers, except in hardship situations in remote or rural areas of the state, where failure to reimburse mileage expenses would severely limit available providers. Mileage authorization requests must be submitted in advance to the local DHCFP District Office for review and may be approved on a case-by-case basis. If approved, the DHCFP District Office will notify the QIO-like vendor to issue an authorization number for the approved mileage to the provider.

2603.1E FLEXIBILITY OF SERVICE DELIVERY

The total weekly authorized hours for PCS may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The recipient will determine how to use the weekly authorized hours on an ongoing basis. Any changes that do not increase the total authorized hours can be made, for the recipient's convenience, within a single week without an additional authorization. Flexibility of services may not take place solely for the convenience of the provider or PCA.

The following requirements must be met:

1. Upon receipt of an initial service plan from the QIO-like vendor, the provider must meet with the recipient in person to determine how the total weekly authorized hours will be provided to meet the individual's needs.
2. Written documentation of the contact with the recipient regarding provision of services must be maintained in the recipient's file.
3. Any change to the approved service plan must be discussed between the provider and the recipient. This may be done either in person or via the telephone in order to determine how hours and tasks will be provided.
4. Changes may be requested on a daily and/or weekly basis when necessary to meet a change in circumstance or condition.
5. The ISO provider must follow their established policies and procedures in order to timely meet recipient requests for changes in service delivery.
6. Written documentation of the contact with the recipient regarding any change to the approved service plan must be maintained in the recipient's file.

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2603.1F CONFLICT OF INTEREST STANDARDS

The DHCFP assures the independence of contracted providers completing the FASPs. Physical and occupational therapists who complete the FAPSs must be an independent third party and may not be:

1. related by blood or marriage to the individual, or to any paid caregiver of the individual;
- ~~1.2.~~ financially responsible for the individual;
3. empowered to make financial or health-related decisions on behalf of the individual; or
4. related by blood or marriage to the Provider who provides PCS to the individual.

The therapist completing the FASP must not have an interest in or employment by a Provider.

Note: To ensure the independence of individuals performing the FASPs, providers are prohibited from contacting the physical or occupational therapists directly.

2603.2 LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

LRI's are individuals who are legally responsible to provide medical support. These individual's include spouses of recipients, legal guardians, and parents of minor recipients, including stepparents, foster parents and adoptive parents. LRI's may not be reimbursed for providing PCS.

If the LRI is not capable of providing the necessary services/supports, he or she must provide verification to the DHCFP's QIO-like vendor, from a physician, that they are not capable of providing the supports due to illness or injury. If not available, verification that they are unavailable due to hours of employment and/or school attendance must be provided. Without this verification, PCS will not be authorized.

Additional verification may be required on a case by case basis.

~~12603.3-~~ PERSONAL CARE REPRESENTATIVE (PCR)

A recipient who is unable to direct their own ~~services-care~~ may opt to utilize a PCR. This individual is directly involved in ~~directs~~ the day-to-day care of the recipient, is available to direct care in the home, acts on behalf of the recipient when the recipient is unable to direct his or her own personal care services and assumes all medical liability associated with directing the recipient's care. A PCR must be a responsible adult.

For the self-directed service delivery model, the PCR is responsible to hires, manages and schedules ~~personal-assistants~~PCAs, assumes responsibility for training, and manages all

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paperwork functions. ~~In addition, the PCR assumes all medical liability associated with directing the recipient's care.~~

The PCR must:

1. effectuate, as much as possible, the decision the individual would make for himself/herself;
2. accommodate the individual, to the extent necessary that they can participate as fully as possible in all decisions that affect them;
3. give due consideration to all information including the recommendations of other interested and involved parties; ~~and~~
4. embody the guiding principles of self-determination; ~~and~~
- 4.5. understand that provision of services is based upon mutual responsibilities between the PCR and the ISO.

A PCR is not eligible to receive reimbursement from Medicaid for this activity. A ~~recipient's paid PCA cannot be the recipient's PCR cannot be the recipient's paid PCA~~. The PCR must meet all criteria outlined in Section 2603.91C of this chapter. In addition, this individual must be present for the provision of ~~available to direct~~ care on a consistent basis, as well as sign daily records. For this reason, it is not allowable for individuals such as a ~~paid PCA~~, care coordinator or ~~case manager an employee of an agency~~ to assume this role.

The PCR may reside outside the home if frequent contact can be made by the recipient, the ISO, and other care providers. The PCR must be available to the recipient, the ISO and other care providers as necessary to fulfill the regular elements of Section 2603.9 of this chapter.

Additionally, if a change in PCR becomes necessary, a new personal care representative agreement must be completed and kept in the recipient's provider file. Contact the ISO to make the necessary changes and to obtain form (s).

~~2.2603PROGRAM ELIGIBILITY CRITERIA~~

- ~~1. The recipient or the PCR must be capable of making choices about ADLs, understand the impact of these choices and assume responsibility for the choices.~~
- ~~b. The PCR may reside outside the home if frequent contact can be made by the recipient, the ISO, and other care providers. The PCR must be available to the recipient, the ISO and other care providers as necessary to fulfill the regular elements of Section 2603.1C of this chapter.~~

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~~e. The recipient or PCR must manage specific documentation and verification functions.~~

~~d. The recipient or PCR must be willing and capable of managing all tasks related to service delivery including, but is not limited to: recruitment, selection, scheduling, training and directing PCAs.~~

2603.4 SERVICES TO CHILDREN

A LRI of a minor child has a duty/obligation to provide the child necessary maintenance, health/medical care, education, supervision and support. Necessary maintenance includes, but is not limited to, the provisions of ADLs and IADLs. Payment will not be made for the routine care, supervision or services normally provided for the child without charge as a matter of course in the usual relationship among members of the nuclear family.

PCS are not a substitute for natural and informal supports provided by family, friends or other available community resources; however, are available to supplement those support systems so the child is able to remain in the home. LRIs may not be reimbursed by Medicaid for PCS services.

PCS for children with disabilities may be appropriate when there is no legally responsible, available, and capable parent or LRI, as defined by the DHCFP, to provide all necessary personal care. Documentation verifying that the recipient's parent or LRI is unavailable or incapable must be provided upon request.

In authorizing PCS services to Medicaid eligible children, the FASP factors in the age and developmental level of the child as well as the parent or LRI's availability and capability to provide the child's personal care needs.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services are available to children under the age of 21. EPSDT may provide a vehicle for receiving medically necessary services beyond the limitations of the PCS benefit. Services must be deemed medically necessary. Authorization of additional services under EPSDT must take into account the responsibilities of the LRI and age-appropriate service provision as discussed above.

Housekeeping tasks are limited directly to the provision of PCS, such as cleaning the bathtub/shower after a bath/shower has been given. Time is allocated under the bathing task and is not an additional service. When a recipient lives with a LRI, it is the responsibility of the LRI to perform specific housekeeping tasks, other than those which are incidental to the performance of Personal Care tasks. This includes, but is not limited to other housekeeping tasks, meal preparation, essential shopping, and escort services.

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A child's LRI must be present during the provision of services. If the LRI cannot be present during the provision of services, a PCR designated by the LRI, other than the PCA, must be present during the time services are being provided.

All other policies in this chapter apply.

2603.5 PCS FOR RECIPIENTS ENROLLED IN HOSPICE

PCS may be provided for recipients enrolled in hospice when the need for PCS is unrelated to the terminal condition, and the personal care needs exceed the PCS provided under the hospice benefit.

If a recipient enrolls in hospice, the DHCFP or its designee will conduct an evaluation of the individual's comprehensive personal care needs to document any needs not met by hospice and which may be provided by the PCA. The evaluation will differentiate between personal care needs unrelated to the terminal condition and those needs directly related to hospice, clearly documenting the total personal care needs. PCS provided under hospice will be subtracted from the total authorized PCS hours.

The PCS provided by a PCA to a recipient because of needs unrelated to the terminal condition may not exceed program limits and guidelines.

2603.6 RESIDENTIAL SUPPORT SERVICES/SUPPORTED LIVING ARRANGEMENT (SLA)

Recipients on the Home and Community Based Waiver for Individuals with Intellectual Disabilities and receiving residential support services through a SLA may receive State Plan PCS if the services are determined to be medically necessary and are non-duplicative of the residential support services being provided. The FASP will be completed factoring in the residential support services.

2603.7~~2~~ SELF-DIRECTED (SD) SKILLED SERVICES

~~SD~~ SD Skilled Services are skilled services provided to a recipient by an unlicensed personal care assistant. This option is offered by Nevada Medicaid under the authority of a ~~covered benefit under a SD Model of the PCS program when authorized in accordance with NRS 629.091, where a provider of healthcare can authorize an unlicensed personal care assistant to provide certain and consistent with Medicaid program requirements. This benefit allows a recipient or their legal representative to direct a PCA to perform~~ specific medical, nursing or home health services, subject to a number of conditions ~~skilled tasks under certain circumstances~~. All skilled ~~S~~services that are self-directed and provided by an unlicensed personal care assistant require a doctor's order and prior authorization. ~~in the recipient's home or in settings outside the home where life activities take place.~~

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2603.7A PROGRAM ELIGIBILITY CRITERIA

In addition to the requirements listed in Section 2603.1A, of the MSM Section 3503.1A.1.a-f and 2603.1A.1.a-d, the following requirements must be met, to be determined eligible for SD Skilled Services:

1. The primary physician has determined the condition of the person with a disability is stable and predictable;
2. The primary physician has determined the procedures involved in providing the services are simple and the performance of such procedures by the personal care assistant does not pose a substantial risk to the person with a disability;
3. A provider of healthcare has determined the personal care assistant has the knowledge, skill and ability to perform the services competently;
4. The PCA agrees with the provider of health care to refer the person with a disability to the primary physician in accordance with NRS 629.091; and
5. Services must be provided in the presence of the legally responsible individual LRI or PCR if the recipient is unable to direct their own care, as in the case of a minor or a cognitively impaired adult, in accordance with NRS 629.091.

2603.7B INITIATING SD SKILLED SERVICES
~~SELF-DIRECTED (SD) SKILLED SERVICES INITIATION~~

The recipient or their PCR indicates interest in the SD Skilled Services Model by contacting their local DHCFP or ADSD District Office directly.

1. The local DHCFP or ADSD District Office staff provides information to the recipient, the LRI, or the PCR about the self-directed services available SD Model. If the recipient is interested in self-direction, a list of enrolled Medicaid ISO providers is provided to the recipient to choose and initiate contact with the ISO of his or her choice.
2. The ISO will provide and the recipient with the Authorization Request for Self-Directed Skilled Services Authorization Form (FA-24C) for completion. will sign Form NMO-3245, ISO SD Specific Medical, Nursing or Home Health Care Services Recipient Agreement Form or if the PCR is directing the recipient's care, the PCR must sign Form NMO-3246, ISO SD Specific Medical, Nursing or Home Health Care Services Personal Representative Agreement form. A copy of either form will be sent to the QIO-like vendor and the ISO shall retain the original for their records.

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- 4.3. The ISO must fax the completed Authorization Request for Self-Directed Skilled Services Authorization ~~forwards~~ Form (FA-24C) and all necessary supporting medical documentation specific to the request to the ~~NMO-3234, ISO Authorization Request, to the QIO-like vendor for processing.~~

~~The recipient and/or the ISO of choice obtains Form NMO 3428A, Provider Authorization Form (physicians order), and NMO 3428B, Training Provider Health Care Authorization (training form), for the QIO-like vendor.~~

~~The QIO-like vendor authorizes or denies the ISO option based on the medical criteria identified in Section 2603.2A.3.~~

~~Recertification is needed annually or when a significant change occurs. Reference MSM Section 3503.1E.1.d for significant change criteria.~~

2603.2A7C COVERAGE AND LIMITATIONS

1. COVERED SERVICES

SD Skilled Services may be approved for recipients who are chronically ill or disabled who require skilled care to remain at home. **The following criteria must be met:**

- a. The service(s) are medically necessary and required to maintain or improve the recipient's health status;:-
- b. The service(s) performed must be one that a person without a disability usually and customarily would personally perform without the assistance of a provider of health care;:-
- c. The service(s) ~~or services~~ must be sufficient in amount, duration and scope to reasonably achieve its purpose;:- **and**
- d. ~~At~~The service(s) must have prior authorization.

2. Non-Covered Services

In addition to the non-covered services listed in Section 2603.1C3 reimbursement is not available for:

- a. Services provided in a physician's office, clinic or other outpatient setting;
- b. SD Skilled Services provided in the absence of a LRI or PCR for those individuals who are not able to direct their own care; or

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- c. Services normally provided by a legally responsible individual or other willing and capable caregiver.

3. ~~MEDICAL CRITERIA~~ **Medical Criteria**

Services must be based on supporting documentation provided by the provider of health care that describes the complexity of the recipient's care and the frequency of skilled interventions. Services must be appropriate, reasonable and necessary for the diagnosis and treatment of the recipient's illness or injury within the context of the recipient's unique medical condition and the standard of practice within the community.

- a. The following criteria are used to establish the appropriate complexity of skilled interventions. The DHCFP or its designee makes the final determination regarding the reasonable amount of time for completion of a task based on supporting documentation, standards of practice, and/or a home health evaluation, as indicated.

1. Limited Skilled Interventions - Interventions that when performed in combination would not reasonably exceed four hours per week. Limited skilled interventions include, but are not limited to: obtaining vital signs or weights; nail care; suprapubic catheter care; attaching a colostomy bag on a wafer or other attachment device that already adheres to the skin; weekly bowel care; skin care, or catheter care; application of opsite, duoderm, or similar product to an abrasion or stage I wound; application of oxygen; monitoring of oxygen saturation levels; nebulizer treatments performed no more frequently than once daily; once a day glucose monitoring; medication set up; administration of non-complex oral medications; suppositories; enemas; subcutaneous or intramuscular injections; eye drops, nose drops, and/or ear drops; application of a medicated patch, or application of a prescription ointment or lotion to ~~less~~ **fewer** than two body parts.

2. Routine Skilled Intervention - Intervention that by its inherent complexity combined with the frequency in the recipient's care routine can reasonably be expected to exceed four hours on a weekly basis. Routine skilled interventions include, but are not limited to: bowel care performed more than once a week; daily pulmonary treatments; nebulizer treatments done more than once a day; catheter changes; stage II to IV wound care; digital stimulation; colostomy care that includes both attaching an colostomy bag on a wafer or other attachment device that already adheres to the skin and changing the wafer or attachment device; multiple straight catheterizations daily; and complex medication administration. Complex medication administration includes, but is not limited to, administration of six or more

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medications on a different frequency schedule, administration of medications through a feeding tube, and glucose testing and insulin administration occurring more than once a day.

3. Highly Complex Intervention - Intervention that by its inherent complexity combined with the frequency in the recipient's care routine can reasonably be expected to exceed one and one-half or more hours per day to perform. Highly complex interventions may include, but are not limited to: tube feedings; special swallow techniques; peritoneal dialysis; stage III or IV wound care; or care of stage II to stage IV wounds in multiple locations. A physician must provide a written rationale for the time requested to perform this intervention.
 - b. Interventions performed on a monthly frequency are not included in calculating the total number of interventions being performed unless the performance of this task requires two (2) or more hours and a physician has provided a written rationale to explain this request. If authorized, this intervention will equal one routine intervention.
 - c. Additional major procedures not listed here may be considered in determining the complexity of skilled intervention. The DHCFP's QIO-like vendor-Central Office, or their designee, should be contacted with information on what the procedure is and the amount of skilled time needed to perform this procedure or task.
 - d. Clinical Decision Support Guide - See Section 2605.32606. The Clinical Decision Support Guide identifies the benefit limitations for individual recipients based upon supporting documentation provided by the physician that describes the complexity of the recipient's care and the frequency of skilled interventions. Services must be appropriate, reasonable and necessary for the diagnosis and treatment of the recipient's illness or injury within the context of the recipient's unique medical condition and the standard of practice within the community.

The QIO-like vendor reviews the request and supporting documentation utilizing criteria identified in the clinical decision support guide. The QIO-like vendor will use these criteria to review for medical necessity and utilization control procedures.
4. ~~CRISIS-OVERRIDE~~ Crisis Override

The SD Skilled Services benefit allows, in rare crisis situations, a short term increase of service hours beyond standard limits. A crisis situation is one that is generally

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unpredictable and puts the individual at risk of institutionalization without the provision of additional hours.

a. Coverage and Limitations

1. Additional services may be covered up to twenty percent (20%) above program limits.
2. Additional services are limited to one (1) 60 day interval in a three year period (calendar years).

The provider must contact the DHCFP ~~Central Office~~ **QIO-like vendor** or a designee with information in writing regarding the crisis situation and need for additional hours. ~~Central Office will notify the QIO-like vendor of the determination.~~

5. ~~NON COVERED SERVICES~~

~~In addition to the non-covered services listed in the MSM Section 3503.1A.4, reimbursement is not available for:~~

- ~~— Services provided in a physician's office, clinic or other outpatient setting;~~
- ~~— SD Skilled Services provided in the absence of a parent or guardian for those individuals who are not able to direct their own care; or~~
- ~~a. Services normally provided by a legally responsible individual or other willing and capable caregiver.~~

~~2603.2B PROVIDER RESPONSIBILITIES~~

~~The intent of SD Skilled Services is to allow the individual being served to self direct, manage and assume responsibility for their own skilled services and to direct the delivery of those services. In addition to those responsibilities identified in Section 2603.1B, it is the responsibility of the ISO or Independent Contractor (IC) if indicated, to ensure all requirements of NRS 629.091 are met in order to receive reimbursement for these services. All required documentation must be made available to the DHCFP or its designee immediately upon request.~~

~~— DOCUMENTATION REQUIREMENTS~~

~~In order to ensure the safety and well-being of the recipient, documentation specific to this option is required and must be signed by all applicable individuals as identified on each form, updated annually and/or with any significant change in condition, and~~

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~~maintained in the recipient's file. Current forms are available upon request from the DHCFP.~~

~~2603.2C~~ — **RECIPIENT RESPONSIBILITIES**

~~The intent of SD Skilled Services is to allow the individual being served to Self Direct, manage and assume responsibility for their own skilled services and to direct the delivery of those services. Participation in this service delivery option is completely voluntary and failure to comply with all of the requirements of this program will result in termination of participation in this service delivery option. Skilled services would then be made available through a licensed Home Health Agency. In addition to those responsibilities identified in 2603.1C, the following requirements apply to all recipients choosing to receive SD Skilled Services:~~

- ~~— The recipient and/or the legal representative are responsible to cooperate fully with their physician and other healthcare providers in order to establish compliance with the requirements set forth in NRS 629.091.~~
- ~~— Where the recipient desires to provide specialized training, and is able to state and convey his/her own needs and preferences to the PCA, information must be documented in the recipient's file identifying the specific training the recipient has provided. The Training Healthcare Provider Authorization form (NMO 3428B) is still required and must be completed by a qualified provider for each PCA who will perform skilled services.~~

~~2603.27D~~ **AUTHORIZATION PROCESS**

~~Prior authorization must be obtained before services can be provided. SD Skilled Services are authorized by the DHCFP's QIO-like vendor. Services must be requested using Ceode T1019 plus a TF modifier to represent SD Skilled Services.~~

~~If the TF modifier is not requested, reimbursement for SD Skilled Services will not be approved and subsequent claims will be denied.~~

- ~~1. The ISO must fax the completed **Authorization Request for Self-Directed Skilled Services Authorization Form (FA-24C)**NMO-3428A, **Provider Authorization Form**, and all necessary supporting medical documentation **specific to the request** to the QIO-like vendor **for processing**. ~~along with other required documentation specific to the SD option of the program.~~~~
- ~~2. The QIO-like vendor reviews the request and supporting documentation utilizing criteria identified in the ~~approved~~ clinical decision support guide. The QIO-like vendor will use these criteria to review for medical necessity and utilization control procedures.~~

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3. Prior authorizations are specific to the recipient, a provider, specific services, established quantity of units and for specific dates of service.
4. Prior authorization is not a guarantee of payment for the service; payment is contingent upon passing all edits contained with the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

~~Reminder: While the authorization will indicate "not to exceed the weekly or monthly total" the provider may only bill for the total number of actual units provided in the calendar week in which they are billing.~~

2603.81B PROVIDER RESPONSIBILITIES~~Y~~

ISO providers shall ensure that services to Medicaid and NCU recipients are provided in accordance to the individual recipient's approved service plan and in accordance with the conditions specified in this chapter and the Medicaid Provider Contract.

Additionally, all ISO providers have ~~the following responsibilities-policies apply to ISO's under the SD Model:~~

1. Certification and/or Licensure

In order to enroll as a Nevada Medicaid ISO provider, all providers must be certified and/or licensed by the DPBH as an ISO or an Agency to Provide Personal Care in the Home and also certified as an ISO.

Providers must comply with licensing requirements and maintain an active certification and/or license at all times.

~~1. The provider must meet the conditions of participation as stated in the MSM Chapter 100.~~

~~2.1. The provider must comply with all local, state and federal regulations and applicable statutes, including but not limited to the Internal Revenue Service (IRS), Federal Income Assessment (FICA), Occupation Safety Hazard Act (OSHA) and Health Insurance Portability and Accountability Act (HIPAA).~~

1.2. Provider Enrollment

To become a Nevada Medicaid ISO provider, the provider must enroll with the QIO-like vendor as an Intermediary Service Organization (provider type 83).

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~~All providers must demonstrate at the time of initial application and upon request, compliance with all administrative and program requirements. Verification of the following administrative and program requirements must be submitted to the DHCFP, or its designee, at the time of application and upon request. Approval as a Medicaid provider of PCS will only be issued once these requirements have been met and verified.~~

~~1. Administrative Requirements — Verification of compliance with these administrative requirements must be provided to the QIO-like vendor at the time of application, at time of contract renewal and upon request:~~

~~a. — proof of certification to operate as an ISO issued by ADSD.~~

~~b. — a fixed land line telephone number published in a public telephone directory. The sole availability of a cell telephone or facsimile line is prohibited.~~

~~c. — accessibility to the public during established and published business hours.~~

~~d. — tax identification name and number (e.g. W-9, SS4).~~

~~e. — workers' compensation insurance for all personnel employed by the ISO.~~

~~f. — Nevada Department of Public Safety (DPS) account for criminal background checks.~~

~~g. — bodily injury and property damage, with minimum combined single limit (CSL) of \$750,000.00 for any owned, hired, and non-owned vehicles used in the performance of the Medicaid provider's contract. The policy shall be endorsed to include the following additional insured language: "The state of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired or borrowed by the Contractor. NOTE: It is the provider's (Contractor's) responsibility to assure that PCAs maintain valid driver's licenses and uninterrupted liability coverage as required by Nevada Revised Statute (NRS) while performing services on behalf of the Contractor.~~

~~h. — commercial crime insurance with minimum limit required of \$25,000 per loss for employee dishonesty, with the DHCFP named as an additional insured.~~

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- ~~2. Program Requirements—Verification of compliance with program requirements must be complete and available for inspection during a pre-contract review conducted by the DHCFP, or its designee, at the provider’s servicing address. Policies must demonstrate the ISO’s commitment to consumer directed principles, while providing the necessary supportive services to ensure the health and safety of the recipient.~~

~~At a minimum this must include:~~

- ~~a. Written policies and procedures for compliance with service delivery including service initiation, verification of recipient eligibility, and recipient education for self-directing care and as a managing employer, as required in this section.~~
- ~~b. Written policies and procedures for initiating and complying with the requirements for Federal Bureau of Investigation (FBI) criminal background checks consistent with ADSD certification requirements. ISO owners, officers, administrators, management and employees must undergo a FBI criminal background check and must provide documentation of such prior to approval of a provider application, and upon request.~~
- ~~c. Written policies and procedures for compliance with the TB testing requirements of this section and are consistent with Nevada Administrative Codes (NAC) 441A.375.~~
- ~~d. Written training policies and procedures for ensuring compliance with requirements, including training curriculum, policies for issuance of training waiver as applicable, certification of completion and competency in required subject matter, as well as maintaining acquired competencies, as required in this section.~~
- ~~e. Written training policies and procedures for ensuring compliance with requirement for educating the recipient or PCR in the skills to act as a managing employer including training curriculum, policies for basic competencies in required subject matter, as well as continued education.~~

- ~~3. Payroll Functions—The provider will provide payroll functions for PCS including the responsibility to:~~

- ~~a. validate PCA timesheets;~~

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~~b. withhold and deposit federal income taxes;~~

~~c. withhold and deposit Social Security and Medicare tax (FICA) and federal and state unemployment tax (FUTA/SUTA) payments;~~

~~d. purchase benefits (e.g., workers' compensation);~~

~~e. assure compliance with all federal and state Department of Labor laws related to minimum wage and overtime; and~~

~~f. generate and issue paychecks.~~

3. The provider must meet the conditions of participation as stated in the MSM Chapter 100.

4. The provider must comply with all local, state and federal regulations and applicable statutes, including but not limited to Nevada Revised Statutes Chapters 449 and 629, the Internal Revenue Service (IRS), Federal Insurance Contributions Act (FICA), Occupational Safety and Health Act (OSHA) and the Health Insurance Portability and Accountability Act (HIPAA).

35. ~~Employer of Record~~ EMPLOYER OF RECORD

The ISO is the employer of record for the PCAs providing services to a Medicaid recipients who chooses this the Self-Directed service delivery model. The ISO shall not serve as the managing employer of the PCA.

~~4. CRIMINAL BACKGROUND CHECKS~~

~~Criminal background checks are a requirement for ISO certification through ADSD. ISO owners, officers, administrators and management must undergo a FBI criminal background check as described in NRS 449.188 and must provide documentation of such prior to ADSD approval of a provider application. Employees or Independent Contractors (IC) of the ISO must undergo a FBI criminal background check as described in NRS 427A.735 through NRS 427A.741.~~

~~Compliance with all criminal background checks requirements is mandatory for initial and continued enrollment as a PCS Medicaid provider.~~

~~Refer to the ADSD ISO website at: http://dhhs.nv.gov/ODS_Programs_ISO.htm for specific requirements and regulations relating to criminal background checks.~~

~~5. TUBERCULOSIS (TB) TESTING~~

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~~Before initial employment, a PCA must have a:~~

- ~~a. physical examination or certification from a licensed physician that the person is in a state of good health, is free from active TB and any other communicable disease in a contagious stage; and~~
- ~~b. TB screening test within the preceding 12 months, including persons with a history of Bacillus Calmette-Guerin (BCG) vaccination.~~

~~If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step TB screening test must be administered. A single annual TB screening test must be administered thereafter.~~

~~An employee with a documented history of a positive TB screening test is exempt from screening with skin tests or chest x ray unless he/she develops symptoms suggestive of TB.~~

~~A person who demonstrates a positive TB screening test shall submit to a chest x-ray and medical evaluation for active TB.~~

~~The annual screening for signs and symptoms must address each of the following areas of concern and must be administered by a qualified health care provider:~~

- ~~a. Has had a cough for more than 3 weeks;~~
- ~~b. Has a cough which is productive;~~
- ~~c. Has blood in his sputum;~~
- ~~d. Has a fever which is not associated with a cold, flu or other apparent illness;~~
- ~~e. Is experiencing night sweats;~~
- ~~f. Is experiencing unexplained weight loss; or~~
- ~~g. Has been in close contact with a person who has active TB.~~

~~Annual screening for signs and symptoms of active disease must be completed prior to the one (1) year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the PCA's file.~~

~~Documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test, signed by the physician or his/her designee,~~

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~~stating the date of the test, the date the test was read, and the results, and maintained in the PCA's file. Any lapse in the required timelines above results in non-compliance with this Section.~~

6. Recipient Education ~~RECIPIENT EDUCATION~~

The ISO ~~must~~ may initiate education of the recipient or PCR in the skills required to act as the managing employer and self-direct care. This may include ~~training tasks related on how to recruit, interview, selecting, managing, evaluate, dismiss and directing the PCA in the delivery of authorized services. Education must begin with an accepted recipient referral and continue throughout the duration of the service provision. Verification of recipient education must be maintained in the recipient's file.~~

7. Personal Care Assistant (PCA) List ~~LIST~~

The ISO shall ~~may~~, upon request, provide a list of PCAs ~~who meet the minimum qualifications as stated in MSM Section 3503.1B.17 and 18~~ to recipients, their LRI or their PCR. The recipient, their LRI or PCR may reference this list in recruiting potential PCAs ~~caregivers~~.

8. Backup List ~~BACKUP LIST~~

The ISO shall maintain and make available to the recipient, their LRI or PCR, on request, a list of qualified PCAs that may be able to provide back-up services. The ISO is not responsible for arranging or ensuring back-up care is provided as this is the responsibility of the, ~~because this is a~~ recipient, their LRI or PCR ~~responsibility~~.

~~9. TIME PARAMETERS~~

~~The ISO has no responsibility to maintain time parameters to provide qualified staff to the recipient after an accepted recipient referral because this is a recipient or PCR responsibility.~~

~~10. 24 HOUR ACCESSIBILITY~~

~~The ISO shall maintain a land line telephone contact during standard business hours for recipient accessibility. This differs from the PCS PA requirement to maintain twenty four (24) hour land line telephone contact.~~

119. Backup Plan ~~BACKUP PLAN~~

The ISO ~~is required to~~ may, upon request, assist the recipient in developing a written back-up plan to address personal care service needs in the event that care is interrupted.

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This may includes ~~making-providing~~ a current ~~copy-list~~ of ~~the-PCAs list~~ available to assist in ~~developing-providing~~ appropriate back-up services. The ISO is responsible for documenting the back-up plan that is developed, but is not responsible for arranging or ensuring back-up care is provided, ~~as this because it~~ is the responsibility of the recipient or PCR ~~to do so~~.

~~12. REFERRAL SOURCE AGREEMENT~~

~~The ISO has no responsibility to establish a written referral service agreement with other Medicaid contracted providers or Home Health Agencies to ensure service coverage for “at risk” recipients on a prospective or back-up basis.~~

10. ~~13. Medicaid and Nevada Check Up~~ ~~MEDICAID AND NEVADA CHECK UP~~ (NCU) ~~eligibility~~ Eligibility

Verification of Medicaid or NCU eligibility ~~on a monthly basis~~ is the responsibility of the ISO.

11. Prior Authorization

The ISO shall obtain prior authorization for services prior to the provision of services. All initial and ongoing services must be prior authorized by the DHCFP’s QIO-like vendor. Services which have not been prior authorized will not be reimbursed.

12. ~~14. Service Initiation~~ ~~SERVICE INITIATION~~

Prior to the ~~beginning-start~~ of services, the ISO staff must review and document with the recipient, ~~their LRI or PCR~~ all components of the MSM ~~Section 3503.1B.14-Chapter 2600~~ and the following items:

- a. The ISO ~~must~~ may initiate education of the recipient or PCR in the skills required to act as managing employer and ~~to self-direct care~~. ~~These skills~~ This may include training on how to recruit, interview, select, ~~managedirect~~, evaluate, ~~and~~ dismiss and direct the PCAs. ~~in the delivery of authorized services~~. Documentation of this ~~requirement~~ must be maintained in the recipient’s file.
- b. The ISO must review with the recipient, ~~their LRI or PCR~~ the approved service plan, ~~allowable-weekly~~ hours, tasks ~~to be provided~~ and required paperwork.
- c. The ISO must review with the recipient, ~~their LRI or PCR~~ his or her responsibility to establish the PCA’s schedule and to establish his or her own back-up plan.

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- d. The ISO provider must review with the recipient, **their LRI** or PCR the differences between the Agency ~~model~~ and the SD **Service Delivery** Model.

13. ~~15.PCS NOT PERMITTED~~ Not Permitted

~~Reference MSM 3503.1B.15.~~

The following are some of the activities that are not within the scope of PCS and are not permitted. This is not an all-inclusive list.

- a. Skilled Care Services requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or certified by the State. PCS services must never be confused with services of a higher level that must be performed by persons with professional training and credentials.
- b. Increasing and/or decreasing time authorized on the approved service plan;
- c. Accepting or carrying keys to the recipient's home;
- d. Purchasing alcoholic beverages for use by the recipient or others in the home unless prescribed by the recipient's physician;
- e. Making personal long-distance telephone calls from the recipient's home;
- f. Performing tasks not identified on the approved service plan;
- g. Providing services that maintain an entire household;
- h. Loaning, borrowing, or accepting gifts of money or personal items from the recipient;
- i. Accepting or retaining money or gratuities for any reason other than that needed for the purchase of groceries or medications for the recipient; and
- j. Care of pets, except in the case where the animal is a certified service animal.

14. ~~16. Supervision~~ SUPERVISION

The ISO must review ~~and document~~ with the recipient, **their LRI** or PCR, ~~their~~ recipient's approved service plan. This must be done each time a new service plan is **approved implemented**. The ~~ISO supervisor~~ must clarify with the recipient, **their LRI** or PCR, ~~their~~ recipient's needs and the tasks to be performed. **Documentation of the approved service plan review must be maintained in the recipient's record.**

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157. ~~Provider Liability~~**PROVIDER LIABILITY**

Provider liability responsibilities are included in the Medicaid and NCU Provider Contract. ~~and are incorporated in this chapter by reference.~~

168. ~~Notification of Suspected Abuse or Neglect~~**NOTIFICATION OF SUSPECTED ABUSE OR NEGLECT**

State law requires that persons employed in certain capacities ~~must~~ make a report to a child protective service agency, ~~an aging and disability services agency~~ or law enforcement agency immediately, but in no event later than 24 hours after there is reasonable cause to ~~suspect~~ believe that a ~~minor~~ child, adult or older person has been abused, ~~or~~ neglected, exploited, isolated or abandoned. ~~The DHCFP expects that all providers be in compliance with the intent of all applicable laws.~~

For recipients under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. For adults' age 60 and over, the ~~Aging and Disability Services Division (ADSD)~~ accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. ~~For all other individuals (other age groups) contact local law enforcement.~~

~~The DHCFP expects that all providers be in compliance with the intent of all applicable laws.~~

- ~~a. Child Abuse Refer to NRS 432B regarding child abuse or neglect.~~
- ~~b. Elder Abuse Refer to NRS 200.5091 to 200.50995 regarding elder abuse, exploitation, or neglect.~~
- ~~c. Other Age Groups For all other individuals or vulnerable persons (NRS 200.5091 to 200.50995) defined as "a person 18 years of age or older who:

 - ~~1. suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or~~
 - ~~2.1. has one or more physical or mental limitations that restrict the ability of the person to perform the normal activities of daily living" contact local law enforcement agencies.~~~~

~~19. COMPLAINT PROCEDURE~~

~~Reference MSM Section 3503.1B.19.~~

2017. Serious Occurrences**SERIOUS OCCURRENCES**

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~~Reference MSM Section 3503.1B.20.~~

The ISO must report all serious occurrences involving the recipient, the PCA, or affecting the provider's ability to deliver services. The Nevada DHCFP Serious Occurrence Report must be completed within 24 hours of discovery and submitted to the local DHCFP District Office. If the recipient is on a Home and Community Based Waiver (HCBW), the notification shall be made directly to the HCBW case manager's ADSD office.

Reportable serious occurrences involving either the recipient or PCA include, but are not limited to the following:

- a. Suspected physical or verbal abuse;
- b. Unplanned hospitalization or ER visit;
- c. Neglect of the recipient;
- d. Exploitation;
- e. Sexual harassment or sexual abuse;
- f. Injuries or falls requiring medical intervention;
- g. An unsafe working environment;
- h. Any event which is reported to Child or Elder Protective Services or law enforcement agencies;
- i. Death of the recipient;
- j. Loss of contact with the recipient for three consecutive scheduled days;
- k. Medication errors;
- l. Theft;
- m. Medical Emergency; or
- n. Suicide Threats or Attempts.

~~21. TERMINATION OF SERVICES~~

~~Reference MSM Section 3503.1B.22.~~

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~~2218. Health Insurance Portability and Accountability Act (HIPAA), Privacy, and Confidentiality~~
~~HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), PRIVACY, AND CONFIDENTIALITY~~

~~Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records and other protected health information is found in MSM Chapter 100.~~

~~2319. Direct Marketing~~
~~DIRECT MARKETING~~

~~Reference MSM Section 3503.1B.12.~~

~~Providers shall not engage in any unsolicited direct marketing practices with any current or potential Medicaid PCS recipient or their LRI. All marketing activities conducted must be limited to the general education of the public or health care providers about the benefits of PCS. Such literature may be printed with the company's logo and contact information, however, this literature may not be distributed, unsolicited, to any current or potential Medicaid PCS recipient(s) or their LRI. The provider may not, directly or indirectly, engage in door-to-door, telephone, direct mail, email or other cold-call marketing activities.~~

~~The provider must ensure that marketing, including plans and materials, are accurate and do not mislead, confuse or defraud current or potential recipients. Statements considered inaccurate, false or misleading include, but are not limited to, any assertion or statement that:~~

- ~~a. the recipient must enroll with the provider in order to obtain benefits or in order not to lose benefits; or~~
- ~~b. the provider is endorsed, certified, or licensed by the DHCFP. Compensation or incentives of any kind which encourage a specific recipient to transfer from one provider to another are strictly prohibited.~~

~~24. CONFLICT OF INTEREST~~

~~Reference MSM Section 3503.1D for conflict of interest standards for PCS functional assessments.~~

~~2520. Records~~
~~RECORDS~~

~~The provider must maintain medical and financial records, supporting documents, and all other records relating to services PCS provided. The provider must retain records for a~~

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period pursuant to the State records retention policy, which is currently six (6) years from the date of payment for the specified service.

- a. If any litigation, claim or audit is started before the expiration of the retention period provided by the DHCFP, records must be retained until all litigation, claims, or audit findings have been finally determined.
 1. The Provider must maintain all required records for each PCA employed by the agency, regardless of the length of employment.
 2. The Provider must maintain the required record for each recipient who has been provided services, regardless of length of the service period.
- b. At a minimum, the Provider must document the following on all service records:
 1. Consistent service delivery within program requirements;
 2. Amount of services provided to recipients;
 3. When services were delivered; and
 4. The services provided and the time spent providing the services. The service record must be initialed daily by the PCA and the recipient, their LRI or PCR to verify service provision.

In the case of electronic service records, the recipient does not have to provide a daily initial on the electronic timesheet to verify daily tasks were provided. The recipient's weekly electronic signature, when the electronic records are completed, verifies the amount of services provided weekly by the PCA and that services were provided in accordance with the approved service plan.
- c. The PCA's supervisor (or other designated agency representative) must review and approve all service delivery records completed by the PCA. The provider will only be paid for the hours and tasks authorized on the approved service plan, which are clearly documented as being provided on the service delivery records. This includes electronic service delivery records.

21. Documentation Requirements

In addition to all of the above responsibilities, if Self-Directed Skilled Services are provided it is the responsibility of the ISO to ensure all requirements of NRS 629.091 are

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met in order to receive reimbursement for these services. All required documentation must be made available to the DHCFP or its designee immediately upon request.

In order to ensure the safety and well-being of the recipient, documentation specific to this option is required and must be signed by all applicable individuals as identified on each form and updated annually with any significant change in condition. Documentation must be maintained in the recipient's file.

All service delivery records completed by the PCA must be reviewed. The provider will only be paid for the hours and tasks which are provided according to the approved service plan and are documented on the service delivery records. This includes electronic service delivery records.

22. Discontinuation of Provider Agreement

a. In the event that a Provider decides to discontinue providing PCS to any of their service areas, the Provider shall:

1. provide all current Medicaid recipients with written notice at least 30 calendar days in advance of service discontinuation advising the recipient will need to transfer to a Medicaid contracted PCS provider. A current list of Medicaid contracted PCS providers must be obtained from the QIO-like vendor and included with the notification;
2. provide the DHCFP with a copy of the written notice of intent to discontinue services, including a list of the affected recipients, at least 30 calendar days in advance of service discontinuation; and
3. continue to provide services through the notice period or until all recipients are receiving services through another Provider, whichever occurs sooner.

b. In the event that the DHCFP discontinues the contractual relationship with a Provider, for any reason, the Provider shall:

1. within five calendar days of receipt of the DHCFP notification to terminate the contractual relationship, send written notification to all their current Medicaid recipients advising the recipient will need to transfer services to a Medicaid contracted PCS provider. A current list of Medicaid contracted PCS providers must be obtained from the QIO-like vendor and be included in this notification.
2. provide reasonable assistance to recipients in transferring services to another provider.

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Providers who fail to satisfactorily meet the requirements discussed above shall be prohibited from participation in a new application for any other PCS provider agreement for a period of not less than one (1) year.

2603.1C9 ~~RECIPIENT/PERSONAL CARE REPRESENTATIVE (PCR)~~ RESPONSIBILITIES AND RIGHTS

1. Recipient Responsibilities

Participation in the SD service delivery option is completely voluntary and failure to comply with any of the responsibilities listed below may result in termination of the recipient's participation in this service delivery option. ~~The recipient must be able to make choices about ADLs, understand the impact of these choices, and assume responsibility for the choices. When this is not possible, and the recipient still expresses an interest in the self directed model, the recipient must have a PCR willing to assist the recipient in making choices related to the delivery of PCS.~~

~~When the recipient utilizes a PCR, the recipient and the PCR must understand the provision of services is based upon mutual responsibilities between the PCR and the ISO.~~

~~The recipient or PCR is responsible for reviewing and signing all required documentation related to the PCS.~~

The recipient, their LRI or PCR will:

- a. notify the provider of changes in Medicaid or NCU eligibility.
- b. notify the provider of current insurance information, including the carrier of other insurance coverage, such as Medicare.
- c. notify the provider of changes in medical status, service needs, address, and location or in changes of status of legally responsible individual(s) or ~~PCR personal representatives.~~
- d. treat all staff appropriately.
- e. ~~Manage specific documentation and verification functions. verify services were provided by signing or initialing the PCA daily record to document the exact date and time the PCA was in attendance and providing services.~~
- f. ~~notify the provider when scheduled visits cannot be kept or services are no longer required.~~
- g. ~~notify the provider of missed visits by provider staff.~~

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~~h. notify the provider of unusual occurrences, or complaints regarding delivery of services, specific staff, or to request a change in caregiver.~~

~~i. give the provider a copy of an Advance Directive, if appropriate.~~

j.f. establish a backup plan in case a PCA is unable to provide services at the scheduled time.

~~k.g. not request a PCA to work more than the hours authorized on the approved service plan.~~

~~l.h. not request a PCA to work or clean for non-recipients.~~

~~m.i. not request a PCA to provide services not on the approved service plan.~~

~~2. In addition, the following policies apply to the SD Model. The recipient or PCR must:~~

~~a. sign all forms related to the SD option provided by the local DHCFP District Office and the QIO-like vendor as appropriate.~~

~~b.j. comply with all Medicaid policies and procedures as outlined in the MSM, all relevant chapters, including Chapters 100 and 3300.~~

~~c.k. recruit, interview, select, schedule, direct and dismiss PCAs.~~

~~d. maintain continuous attendant coverage in arranging and scheduling additional PCA coverage for vacation, holidays, sickness or other unscheduled absence of a regularly scheduled PCA.~~

~~e.l. develop a backup plan in the event of failure to maintain continuous coverage of regularly scheduled PCAs.~~

~~f.m. Verify services were provided according to the approved service plan and/or doctor's orders by, whenever possible, signing or initialing the PCA documentation of the exact date and time the PCA was in attendance and providing services. review, verify and sign daily records to ensure the service plan has been followed. A daily record form must be signed or initialed by the PCA, recipient or the PCR, attesting to the services provided and the time spent providing the service. (See Daily Record definition located in the Addendum regarding signature or initial requirements.) Misrepresentation within this process constitutes fraud per NRS 422.540 and NRS 422.550.~~

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- ~~g-n.~~ inform the PCA of the existence ~~and location~~ of advance directive documents, if these are available, ~~and provide a copy to the ISO, if appropriate.~~
- ~~h-o.~~ notify the ISO and the recipient's case manager, if applicable, or the local DHCFP District Office ~~when the recipient, their LRI or PCR no longer wish to self-direct their services and to~~ request care ~~be provided~~ through a provider agency.
- ~~j-p.~~ cooperate with the DHCFP or its designee in conducting compliance reviews, investigations, or audits.
- ~~i-q.~~ specify any and all specialized training requirements of the PCA and assure that the specified training has been received.
- ~~j-r.~~ obtain re-certification for continued services according to ~~regulation~~ policy. This ~~will~~ may require that a FASP ~~functional assessment, service plan,~~ and/or a new authorization request for Self-Directed Skilled Services Form ~~all forms associated with self-direction of services~~ be completed.

In addition to the responsibilities identified above, the following requirements are applicable to all recipients that opt to self-direct their Skilled Services.

- s. The recipient, LRI and/or PCR are responsible to cooperate fully with the physician and other healthcare providers in order to establish compliance with the requirements set forth in NRS 629.091.
- t. When the recipient desires to provide specialized training, and is able to state and convey his/her own needs and preferences to the PCA, information must be documented in the recipient's file identifying the specific training the recipient has provided.
- u. The authorization request for Self-Directed Skilled Services Form is required and must be completed by a qualified provider for each personal care assistant who will perform the skilled services.

2. Recipient Rights

Every Medicaid and NCU recipient receiving PCS or SD Skilled Services, their LRI or PCR, has the right to:

- a. request a change in service delivery model from the Self-Directed model provided through an ISO to the Provider Agency model for their PCS or a Home Health Agency for their skilled services;

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- b. receive considerate and respectful care that recognizes the inherent worth and dignity of each individual;
- c. participate in the development process and receive an explanation of authorized services;
- d. receive a copy of the approved service plan;
- e. contact the local DHCFP District Office, with questions, complaints, or for additional information;
- f. receive assurance that privacy and confidentiality about one's health, social, domestic and financial circumstances will be maintained pursuant to applicable statutes and regulations;
- g. know that all communications and records will be treated confidentially;
- h. expect all providers, within the limits set by the approved service plan and within program criteria, to respond in good faith to the recipient's reasonable requests for assistance;
- i. receive information upon request regarding the DHCFP's policies and procedures, including information on charges, reimbursements, FASP determinations, and the opportunity for fair a hearing;
- j. request a change of provider;
- k. have access, upon request, to his or her Medicaid recipient files;
- l. request a Fair Hearing if there is disagreement with the DHCFP's action(s) to deny, terminate, reduce, or suspend services; and
- m. receive upon request the telephone number of the Office for Consumer Health Assistance.

~~The recipient or the PCR may discontinue this option at any time and return to the PCS Agency P/T 30 option referenced in MSM Chapter 3500. Additionally, if a change in PCR becomes necessary a new PCR agreement form must be signed. Contact the local DHCFP District Office for the necessary form.~~

~~2603.1D — AUTHORIZATION PROCESS~~

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~~The policies discussed in the MSM Section 3503.1E, apply to the SD Model.~~

~~2603.2 SELF-DIRECTED (SD) SKILLED SERVICES~~

~~SD Skilled Services are a covered benefit under a SD Model of the PCS program when authorized in accordance with NRS 629.091 and consistent with Medicaid program requirements. This benefit allows a recipient or their legal representative to direct a PCA to perform specific skilled tasks under certain circumstances. Services are provided in the recipient's home or in settings outside the home where life activities take place.~~

~~a. SELF-DIRECTED (SD) SKILLED SERVICES INITIATION~~

~~The recipient or their PCR indicates interest in the SD Skilled Services Model by contacting the DHCFP District Office directly.~~

~~2.1. The DHCFP or ADSD District Office staff provides information to the recipient or the PCR about the SD Model. If the recipient is interested in self-direction, a list of ISOs is provided to the recipient to choose and initiate contact with the ISO of his or her choice.~~

~~3.1. The ISO will provide and the recipient will sign Form NMO 3245, ISO SD Specific Medical, Nursing or Home Health Care Services Recipient Agreement Form or if the PCR is directing the recipient's care, the PCR must sign Form NMO 3246, ISO SD Specific Medical, Nursing or Home Health Care Services Personal Representative Agreement form. A copy of either form will be sent to the QIO-like vendor and the ISO shall retain the original for their records.~~

~~4.1. The ISO forwards Form NMO 3234, ISO Authorization Request, to the QIO-like vendor.~~

~~5.1. The recipient and/or the ISO of choice obtains Form NMO 3428A, Provider Authorization Form (physicians order), and NMO 3428B, Training Provider Health Care Authorization (training form), for the QIO-like vendor.~~

~~6.1. The QIO-like vendor authorizes or denies the ISO option based on the medical criteria identified in Section 2603.2A.3.~~

~~Recertification is needed annually or when a significant change occurs. Reference MSM Section 3503.1E.1.d for significant change criteria.~~

~~2603.2A COVERAGE AND LIMITATIONS~~

~~1. PROGRAM ELIGIBILITY CRITERIA~~

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~~In addition to the requirements of the MSM Section 3503.1A.1.a-f and 2603.1A.1.a-d, the following requirements must be met, to be determined eligible for SD Skilled Services:~~

- ~~a. The primary physician has determined the condition of the person with a disability is stable and predictable;~~
- ~~b.a. The primary physician has determined the procedures involved in providing the services are simple and the performance of such procedures by the personal care assistant does not pose a substantial risk to the person with a disability;~~
- ~~e.a. A provider of healthcare has determined the personal care assistant has the knowledge, skill and ability to perform the services competently;~~
- ~~d.a. The PCA agrees with the provider of health care to refer the person with a disability to the primary physician in accordance with NRS 629.091; and~~
- ~~1.a. Services must be in the presence of the legally responsible individual if the recipient is unable to direct their own care, as in the case of a minor or a cognitively impaired adult, in accordance with NRS 629.091.~~

~~2.1. COVERED SERVICES~~

- ~~a. SD Skilled Services may be approved for recipients who are chronically ill or disabled who require skilled care to remain at home.~~
- ~~b.a. The services are medically necessary and required to maintain or improve the recipient's health status.~~
- ~~e.a. The service performed must be one that a person without a disability usually and customarily would personally perform without the assistance of a provider of health care.~~
- ~~d.a. The service or services must be sufficient in amount, duration and scope to reasonably achieve its purpose.~~
- ~~e.a. All services must have prior authorization.~~

~~3.1. MEDICAL CRITERIA~~

~~Services must be based on supporting documentation provided by the provider of health care that describes the complexity of the recipient's care and the frequency of skilled interventions. Services must be appropriate, reasonable and necessary for the diagnosis~~

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~~and treatment of the recipient's illness or injury within the context of the recipient's unique medical condition and the standard of practice within the community.~~

~~b.a. The following criteria are used to establish the appropriate complexity of skilled interventions. The DHCFP or its designee makes the final determination regarding the reasonable amount of time for completion of a task based on supporting documentation, standards of practice, and/or a home health evaluation, as indicated.~~

~~1. Limited Skilled Interventions Interventions that when performed in combination would not reasonably exceed four hours per week. Limited skilled interventions include, but are not limited to: obtaining vital signs or weights; nail care; suprapubic catheter care; attaching a colostomy bag on a wafer or other attachment device that already adheres to the skin; weekly bowel care; skin care, or catheter care; application of opsite, duoderm, or similar product to an abrasion or stage I wound; application of oxygen; monitoring of oxygen saturation levels; nebulizer treatments performed no more frequently than once daily; once a day glucose monitoring; medication set up; administration of non-complex oral medications; suppositories; enemas; subcutaneous or intramuscular injections; eye drops, nose drops, and/or ear drops; application of a medicated patch, or application of a prescription ointment or lotion to less than two body parts.~~

~~2.1. Routine Skilled Intervention Intervention that by its inherent complexity combined with the frequency in the recipient's care routine can reasonably be expected to exceed four hours on a weekly basis. Routine skilled interventions include, but are not limited to: bowel care performed more than once a week; daily pulmonary treatments; nebulizer treatments done more than once a day; catheter changes; stage II to IV wound care; digital stimulation; colostomy care that includes both attaching an colostomy bag on a wafer or other attachment device that already adheres to the skin and changing the wafer or attachment device; multiple straight catheterizations daily; and complex medication administration. Complex medication administration includes, but is not limited to, administration of six or more medications on a different frequency schedule, administration of medications through a feeding tube, and glucose testing and insulin administration occurring more than once a day.~~

~~3.1. Highly Complex Intervention Intervention that by its inherent complexity combined with the frequency in the recipient's care routine can reasonably be expected to exceed one and one half or more hours per day to perform. Highly complex interventions may include, but are not limited to: tube feedings; special swallow techniques; peritoneal dialysis;~~

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~~stage III or IV wound care; or care of stage II to stage IV wounds in multiple locations. A physician must provide a written rationale for the time requested to perform this intervention.~~

~~e.a. Interventions performed on a monthly frequency are not included in calculating the total number of interventions being performed unless the performance of this task requires two (2) or more hours and a physician has provided a written rationale to explain this request. If authorized, this intervention will equal one routine intervention.~~

~~d.a. Additional major procedures not listed here may be considered in determining the complexity of skilled intervention. The DHCFP Central Office, or their designee, should be contacted with information on what the procedure is and the amount of skilled time needed to perform this procedure or task.~~

~~e.a. Clinical Decision Support Guide See Section 2605.3. The clinical decision support guide identifies the benefit limitations for individual recipients based upon supporting documentation provided by the physician that describes the complexity of the recipient's care and the frequency of skilled interventions. Services must be appropriate, reasonable and necessary for the diagnosis and treatment of the recipient's illness or injury within the context of the recipient's unique medical condition and the standard of practice within the community.~~

~~The QIO-like vendor reviews the request and supporting documentation utilizing criteria identified in the clinical decision support guide. The QIO-like vendor will use these criteria to review for medical necessity and utilization control procedures.~~

~~4. CRISIS OVERRIDE~~

~~The SD Skilled Services benefit allows, in rare crisis situations, a short term increase of service hours beyond standard limits. A crisis situation is one that is generally unpredictable and puts the individual at risk of institutionalization without the provision of additional hours.~~

~~a. Coverage and Limitations~~

~~1. Additional services may be covered up to twenty percent (20%) above program limits.~~

~~2. Additional services are limited to one (1) 60 day interval in a three year period (calendar years).~~

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~~The provider must contact the DHCFP Central Office or a designee with information in writing regarding the crisis situation and need for additional hours. Central Office will notify the QIO like vendor of the determination.~~

~~5. NON COVERED SERVICES~~

~~In addition to the non covered services listed in the MSM Section 3503.1A.4, reimbursement is not available for:~~

- ~~a. Services provided in a physician's office, clinic or other outpatient setting;~~
- ~~b. SD Skilled Services provided in the absence of a parent or guardian for those individuals who are not able to direct their own care; or~~

~~Services normally provided by a legally responsible individual or other willing and capable caregiver.~~

~~2603.2B PROVIDER RESPONSIBILITIES~~

~~The intent of SD Skilled Services is to allow the individual being served to self direct, manage and assume responsibility for their own skilled services and to direct the delivery of those services. In addition to those responsibilities identified in Section 2603.1B, it is the responsibility of the ISO or Independent Contractor (IC) if indicated, to ensure all requirements of NRS 629.091 are met in order to receive reimbursement for these services. All required documentation must be made available to the DHCFP or its designee immediately upon request.~~

~~1. DOCUMENTATION REQUIREMENTS~~

~~In order to ensure the safety and well-being of the recipient, documentation specific to this option is required and must be signed by all applicable individuals as identified on each form, updated annually and/or with any significant change in condition, and maintained in the recipient's file. Current forms are available upon request from the DHCFP.~~

~~2603.2C RECIPIENT RESPONSIBILITIES~~

~~The intent of SD Skilled Services is to allow the individual being served to Self Direct, manage and assume responsibility for their own skilled services and to direct the delivery of those services. Participation in this service delivery option is completely voluntary and failure to comply with all of the requirements of this program will result in termination of participation in this service delivery option. Skilled services would then be made available through a licensed Home Health Agency. In addition to those responsibilities identified in 2603.1C, the following requirements apply to all recipients choosing to receive SD Skilled Services:~~

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~~1. The recipient and/or the legal representative are responsible to cooperate fully with their physician and other healthcare providers in order to establish compliance with the requirements set forth in NRS 629.091.~~

~~2.1. Where the recipient desires to provide specialized training, and is able to state and convey his/her own needs and preferences to the PCA, information must be documented in the recipient's file identifying the specific training the recipient has provided. The Training Healthcare Provider Authorization form (NMO 3428B) is still required and must be completed by a qualified provider for each PCA who will perform skilled services.~~

~~2603.2D AUTHORIZATION~~

~~Prior authorization must be obtained before services can be provided. SD Skilled Services are authorized by the DHCFP's QIO-like vendor. Services must be requested using code T1019 plus a TF modifier to represent SD Skilled Services.~~

~~If the TF modifier is not requested, reimbursement for SD Skilled Services will not be approved and subsequent claims will be denied.~~

~~1. The ISO must fax the completed Form NMO 3428A, Provider Authorization Form, and all necessary supporting medical documentation to the QIO-like vendor along with other required documentation specific to the SD option of the program.~~

~~2.1. The QIO-like vendor reviews the request and supporting documentation utilizing criteria identified in the approved clinical decision support guide. The QIO-like vendor will use these criteria to review for medical necessity and utilization control procedures.~~

~~3.1. Prior authorizations are specific to the recipient, a provider, specific services, established quantity of units and for specific dates of service.~~

~~4.1. Prior authorization is not a guarantee of payment for the service; payment is contingent upon passing all edits contained with the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.~~

~~Reminder: While the authorization will indicate "not to exceed the weekly or monthly total" the provider may only bill for the total number of actual units provided in the calendar week in which they are billing.~~

~~2603.3 PCS INDEPENDENT CONTRACTOR (IC) MODEL~~

~~A PCA may independently contract with the DHCFP in accordance with Chapter 100 to provide SD Skilled Services and PCS in a recipient's residence or in a location outside the home, except~~

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~~as excluded per 1905(a)(24) of the Social Security Act. An individual may only apply to the DHCFFP to become a PCA-IC when the need and preference for SD Skilled Services exists, where no PCR or ISO is available and when the absence of an IC would constitute a hardship for an eligible recipient. A hardship situation is one in which the recipient is considered to be "at risk".~~

~~PCS Application to become an IC is made through the local DHCFFP District Office. Each IC providing PCS services must comply with all PCS program criteria. The local DHCFFP District Office will inform the potential PCA-IC of program criteria, training requirements, etc. The local DHCFFP District Office will assist in processing the PCA's application which must be submitted to the QIO-Like vendor. Once the IC is approved and a recipient assignment is made, the local DHCFFP District Office care coordinator will provide the IC with the recipient's service plan and authorized service hours. The local DHCFFP District Office care coordinator will monitor compliance with IC requirements and PCS program criteria.~~

~~2603.3A COVERAGE AND LIMITATIONS~~

~~All of the policies discussed in the MSM Section 3503.1A apply to the IC option.~~

~~2603.3B PROVIDER RESPONSIBILITIES~~

~~The IC must assist eligible Medicaid recipients with ADLs and IADLs, as identified on the individual recipient's service plan and in accordance with the conditions specified in this Chapter, and the Medicaid Provider Contract, as well as SD Skilled Services pursuant to NRS 629.091. Each IC providing PCS and SD Skilled Services must comply with PCS program criteria.~~

~~In order to ensure the safety and well-being of the recipient, documentation specific to the SD Skilled Services option of the program is required and must be signed by all applicable individuals as identified on each form, and updated annually and/or with any significant change in condition. Current forms are available upon request from the DHCFFP or the QIO-like vendor.~~

~~1. PROVIDER ENROLLMENT~~

~~The PCA's application must be submitted to the QIO-Like vendor and include:~~

~~a. Tax Identification (ID) number.~~

~~b.a. Proof of FBI Background Check.~~

~~e.a. Documentation specific to the SD Skilled Services option.~~

~~The following policies apply to the IC option:~~

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~~d.a. The IC must verify Medicaid Eligibility monthly.~~

~~e.a. The Provider shall provide PCS in ADLs and IADLs which are medically necessary and approved on the service plan. The services provided must not exceed the PCA scope of services or limitations defined elsewhere in the MSM.~~

~~f.a. The IC must review the recipient's service plan with the recipient or their PCR prior to the initiation of services. The IC shall review all allowable tasks, excluded activities and recipient back up plan. Documentation must be maintained in the recipient's file that this requirement has been met.~~

~~g.a. 24 Hour Accessibility~~

~~The IC should have reasonable phone access either through a cell phone or home telephone for contact by the recipient or PCR. The IC is not required to maintain 24 hour phone accessibility.~~

~~h.a. Backup Mechanism~~

~~The IC has no responsibility to establish a back up mechanism in the event of an unanticipated, unscheduled absence because this is a recipient or PCR responsibility. The IC must notify the recipient at least two (2) weeks in advance of anticipated time off (vacation, elective surgery etc.).~~

~~i.a. Referral Source Agreement~~

~~The IC has no responsibility to establish a referral source agreement as there are no provider agencies within the immediate geographical area.~~

~~j.a. Administrative Functions~~

~~The IC must comply with all state regulations regarding independent contractors.~~

~~k.a. Service Initiation~~

~~Prior to initiation of services and periodically as needed, the IC must review with the recipient or PCR, the following:~~

- ~~1. Advanced Directive, including their right to make decisions about their health care, and the right to execute a living will or grant power of attorney to another individual. Refer to MSM Chapter 100 for further information.~~

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~~2.1. Procedure to be followed when a PCA does not appear at a scheduled visit or when an additional visit is required.~~

~~3.1. The non-covered service/tasks of the PCS program.~~

~~4.1. The procedure and form used to verify PCA attendance.~~

~~5.1. The recipient's service plan or any changes in the service plan, including the following:~~

~~a. Authorized service hours;~~

~~b.a. PCA's schedule;~~

~~e.a. PCA's assigned tasks and pertinent care provided by informal supports; and~~

~~d. The recipient's back up plan.~~

~~l.a. Supervision~~

~~The IC is not required to meet the supervisory requirement of the PCS agency. As an IC the provider is required to perform all PCA services.~~

~~m.a. Training~~

~~The IC has 60 days to meet the basic training requirements and to obtain Cardiopulmonary Resuscitation (CPR) certification. Waiver of the basic training requirements may be permitted if the criteria for waiver competency are met. The local District Office may be available to assist with the determination that competency exists. Documentation of completion of the required subject areas must be provided to the local District Office.~~

~~1. Basic Training Basic training shall involve community resources, such as public health nurses, home economists, physical therapists, and social workers. An outline of content of each subject shall be maintained by the provider.~~

~~Basic training shall be a minimum of 16 hours in length. Basic training must include content in all of the following areas:~~

~~a. Orientation to the service plan, community and the DHCFP medical assistance program services;~~

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- ~~b.a. Body mechanics and transfer techniques;~~
- ~~e.a. Bathing, basic grooming and mobility techniques, including simple non-prescribed range of motion;~~
- ~~d.a. Personal care skills, including PCS permitted and not permitted (refer to section 3503.1A);~~
- ~~e.a. Care of the home and personal belongings;~~
- ~~f.a. Infection control, including information on common communicable diseases, blood borne pathogens, infection control procedures, universal precautions and applicable Occupation Safety Hazard Act (OSHA) requirements;~~
- ~~g.a. Household safety and accident prevention, including information on general household safety and how to prevent accidents, poisoning, fires etc. and minimizing the risk of falls;~~
- ~~h.a. food, nutrition and meal preparation, including information on a well balanced diet, special dietary needs and the proper handling and storage of food;~~
- ~~i.a. Bowel and bladder care, including routine care associated with toileting, routine maintenance of indwelling catheter drainage system (emptying bag, positioning, etc.), routine care of colostomies (emptying bag, changing bag), signs and symptoms of urinary tract infections, and common bowel problems such as constipation and diarrhea;~~
- ~~j.a. Skin care, including interventions to prevent pressure sores, (repositioning, use of moisturizers, etc.), routine inspections of skin, and reporting skin redness, discoloration or breakdown to the recipient or caregiver;~~
- ~~k.a. Health oriented record keeping, including written documentation of services provided and time verification records;~~
- ~~l.a. Recipient's rights, including confidentiality pursuant to state and federal regulations and consumer rights;~~
- ~~m.a. Communication skills, including basic listening and verbal communication skills, problem solving and conflict resolution~~

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~~skills, as well as alternative modes of communication techniques for individuals with communication or sensory impairments;~~

~~n.a. Information including overview of aging and disability (sensory, physical and cognitive) regarding changes related to the aging process, sensitivity training towards aged and disabled individuals, recognition of cultural diversity and insights into dealing with behavioral issues;~~

~~o.a. Advance directives, including information regarding the purpose of an advance directive and implications for the PCA; and~~

~~p.a. CPR certification, which may be obtained outside the agency. Online CPR training is insufficient to meet the requirements of this section. PCAs must physically attend and successfully pass a CPR certification training which includes demonstration of competencies in administering CPR. Documentation of current CPR certification must be maintained in each PCA's file by the provider.~~

~~n.a. PCA Employment Standards – Minimum Qualifications~~

~~Reference MSM Chapter 3503.1B.17.~~

~~o.a. Records~~

~~The IC must maintain medical and financial records, supporting documents, and all other records relating to PCS provided. The provider must retain records for a period pursuant to the State records retention policy, which is currently six (6) years from the date of payment for the specified service.~~

~~p.a. HIPAA, Privacy, and Confidentiality~~

~~Refer to MSM Chapter 100 for information on HIPAA, privacy, and confidentiality of recipient records and other protected health information.~~

~~q. Notification of Suspected Abuse or Neglect~~

~~Reference MSM Chapter 3503.1B.21~~

~~r. Prior Authorization~~

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~~Prior authorization must be obtained before services can be provided. PCS is authorized by the DHCFP's QIO-like vendor. The IC shall obtain prior authorization for all initial and ongoing services.~~

~~2603.3C RECIPIENT RESPONSIBILITIES~~

~~All of the policies discussed in the MSM Section 3503.1C, apply to the IC model.~~

~~2603.3D AUTHORIZATION PROCESS~~

~~All of the policies discussed in the MSM Section 3503.1E, apply to the IC option.~~

2603.410 ESCORT SERVICES

Escort services may be authorized in certain situation for recipients who require a PCA to perform an approved PCS en route to or while obtaining Medicaid reimbursable services. ~~All of the policies discussed in MSM Section 3503.8 apply.~~

2603.10A COVERAGE AND LIMITATIONS

Escort services may be authorized as a separate billable service when all the following conditions are met:

1. The needed PCS is currently an authorized task on the approved service plan and will be provided during the course of the visit.
2. The PCS required are an integral part of the visit. Covered personal care tasks would include undressing/dressing, toileting, transferring/positioning, ambulation and eating. For example, transferring a recipient on and off an examination table is an integral part of a physician visit.
3. A LRI is unavailable or incapable of providing the personal care task en route to or during the appointment.
4. Staff at the site of the visit (surgery center, physician's office, clinic setting, outpatient therapy site or other Medicaid reimbursable setting) is unable to assist with the needed personal care task.

2603.10B AUTHORIZATION PROCESS

1. The provider must contact the QIO-like vendor for prior authorization for escort services.

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2. Service should be requested as a single service authorization request. The provider must document the medical necessity of the services.

3. A new FASP is not required in this situation.

2603.10C PROVIDER RESPONSIBILITY

1. The provider must verify that all conditions above are met when asking for an escort services authorization.

2. The provider must include all the above information when submitting the prior authorization request, including the date of service and the amount of time requested. The provider must comply with all other policies in Section 2603.1D of this chapter.

2603.511 TRANSPORTATION

Transportation of the recipient in a ~~Provider's vehicle, or the PCA's private vehicle or any other vehicle~~ is not a covered service and is not reimbursable service and is strongly discouraged by the DHCFP. Recipients who choose to be transported by ~~the in Provider or PCA vehicles~~ do so at their own risk.

Refer to MSM Chapter 1900, Transportation Services, for requirements of the DHCFP medical transportation program. Medicaid may reimburse for necessary and essential medical transportation to and from medical providers.

~~Transportation of the recipient in a Provider vehicle or the PCA's private vehicle is not a reimbursable service and is strongly discouraged by the DHCFP. Recipients who choose to be transported in Provider or PCA vehicles do so at their own risk.~~

2603.12 REIMBURSEMENT

Medicaid reimbursement is made directly to the Provider Agency for services billed using Service Code T1019 for PCS or T1019TF for SD Skilled. The reimbursement rate is based on a contracted rate which takes into consideration and includes the costs associated with doing business. Consequently, separate reimbursement is not available for the following:

1. Time spent completing administrative functions such as supervisory visits, scheduling, chart audits, surveys, review of service delivery records and personnel consultant;
2. The cost of criminal background checks and TB testing;
3. Travel time to and between recipients home;

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4. The cost of basic training, in-service requirements and the CPR and First Aid requirement; and/or
5. Routine supplies customarily used during the course of visits, including but not limited to non-sterile gloves.

2603.13 IMPROPER BILLING PRACTICES

Providers must bill only for the dates when services were actually provided, in accordance with the appropriate billing manual.

Any provider found by the State or its agent(s) to have engaged in improper billing practices, without limitations, may be subject to sanctions including recoupment, denial or termination from participation in Nevada Medicaid.

The findings and conclusions of any investigation or audit by the DHCFP shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.

Improper billing practices may include, but are not limited to:

1. submitting claims for unauthorized visits;
2. submitting claims for services not provided, for example billing a visit when the recipient was not at home but the PCA was at the recipients residence;
3. submitting claims for visits without documentation to support the claims billed.
 - a. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the recipient's signature, the month, day, year, and time in and out of the recipient's home. Providers shall submit or produce such documentation upon request by the DHCFP staff;
4. submitting claims for unnecessary visits or visits that are in excess of amount, scope and duration necessary to reasonably achieve its purpose;
5. billing for the full authorized number of units when they exceed the actual amount of service units provided; or
6. submitting claims for PCS provided by an unqualified paid PCA.

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Any PCS or other provider who improperly bills the DHCFP for services rendered is subject to all administrative and corrective sanctions and recoupments listed in the MSM Chapter 3300. All Medicaid overpayments are subject to recoupment.

Any such action taken against a provider by the DHCFP has no bearing on any criminal liability of the provider.

2603.614 QUALITY ASSURANCE

The DHCFP and/or ADSD will conduct an annual reviews, announced or unannounced, to evaluate the provider's compliance with this chapter and any other regulatory requirement. assure the health, welfare and satisfaction with services and freedom of choice of the recipients served by these programs.

These Reviews will consist of, but are not limited to, a desk pre-audit review by of information to be submitted to the DHCFP and/or ADSD review staff and/or prior to an onsite visit review. an onsite review to evaluate the providers' compliance with this chapter, Chapter 3500, Chapter 100 and other regulatory requirements, and include a post-review conference and written report. Providers must cooperate with the review process. Additionally, a reviews of the providers will be conducted annually to verify that the providers meet requirements established for each service, such as licensure, accreditation, etc., and to ensure services are being provided and billed for accordingly, and that claims for those services are paid in accordance with the State Plan, this chapter and all federal and state regulations. Providers must cooperate with the DHCFP's annual review process.

Quality Assurance Reviews will also be done by the DHCFP to determine program the health and welfare, service satisfaction, and freedom of choice of the recipients receiving PCS and/or Skilled Services. quality and recipient satisfaction.

Reviews will consist of but are not limited to, a pre-audit review of information to be submitted to the DHCFP review staff prior to an onsite visit, an onsite review to evaluate the providers' compliance with this chapter, Chapter 3500, Chapter 100 and other regulatory requirements, and include a post-review conference and written report.

Quality Assurance reviews will also be done by the DHCFP to determine program quality and recipient satisfaction.

2603.15 ADVERSE ACTIONS

An adverse action refers to a denial, termination, reduction or suspension of an applicant or recipient's request for services or eligibility determination.

For the purposes of this Chapter, the DHCFP or their designee takes adverse action when:

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1. the recipient is not eligible for Medicaid;
2. the recipient does not meet the PCS eligibility criteria;
3. the recipient, their LRI or the PCR refuses services or is non-cooperative in the establishment or delivery of services;
4. the recipient, their LRI or the PCR refuses to accept services in accordance with the approved service plan;
5. all or some services are no longer necessary as demonstrated by the FASP;
6. the recipient's needs can be met by a LRI;
7. the recipient's parent and/or legal guardian is responsible for the maintenance, health care, education and support of their child;
8. services requested exceed service limits;
9. services requested are non-covered benefits (refer to 2603.1C.3); or
10. another agency or program provides or could provide the services.

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26043.3 PCS INDEPENDENT CONTRACTOR (IC) MODEL

An individual-PCA may independently contract with the DHCFP in accordance with Chapter 400 to provide SD Skilled Services and PCS in a recipient's residence or in a location outside the home, except as excluded per 1905(a)(24) of the Social Security Act. An individual may only apply to the DHCFP to become a PCSA IC when the need and preference for SD Skilled Services exists, where no PCS Agency PCR or ISO is available and when the absence of an IC would constitute a hardship for an eligible recipient. A hardship situation is one in which the recipient is considered to be "at risk".

An PCS Application to become an IC with Nevada Medicaid is made through the local DHCFP District Office. Each IC providing PCS services must comply with all PCS program criteria. The local DHCFP District Office will inform the potential PCA-IC of program criteria, training requirements, etc. The local DHCFP District Office will assist in processing the IC's PCA's application which must be submitted to the QIO-Like vendor. Once the IC is approved, and a recipient assignment is made, the local DHCFP District Office care coordinator will provide notify the appropriate ADSD case manager who will provide the IC with the recipient's service plan and authorized service hours. The local DHCFP District Office care coordinator will monitor compliance with IC requirements and PCS program criteria.

26043.13A COVERAGE AND LIMITATIONS

All of the policies discussed in the MSM Section 3503.1A-2603.1C and 2603.7C of this chapter apply to the IC option.

26034.3D1B AUTHORIZATION PROCESS

Prior authorization must be obtained before services can be provided. PCS is authorized by the ADSD case manager. The IC shall contact the recipient's ADSD case manager to obtain prior authorization for services. All of the policies discussed in the MSM Section 3503.1E, apply to the IC option.

26034.3B1C PROVIDER RESPONSIBILITIES

The IC must assist eligible Medicaid recipients with ADLs and IADLs, as identified on the individual recipient's service plan and in accordance with the conditions specified in this Chapter, and the Medicaid Provider Contract, as well as SD Skilled Services pursuant to NRS 629.091. Each IC providing PCS and SD Skilled Services must comply with PCS program criteria.

In order to ensure the safety and well-being of the recipient, documentation specific to the SD Skilled Services option of the program is required and must be signed by all applicable

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individuals as identified on each form, and updated annually and/or with any significant change in condition. Current forms are available upon request from the DHCFP or the QIO-like vendor.

1. Provider Enrollment

To become a Nevada Medicaid provider, the IC must enroll with the QIO-like vendor as a Provider Type 58, Specialty 189. The PCA's application must be submitted to the QIO-Like vendor and include:

- a. Tax Identification (ID) number.
- b. Proof of FBI Background Check.
- c. Documentation specific to the SD Skilled Services option.

2. The following policies apply to the IC option:

- a. The IC must verify Medicaid Eligibility monthly.
- b. The Provider shall provide PCS in ADLs and IADLs which are medically necessary and approved on the service plan. The services provided must not exceed the PCA scope of services or limitations defined elsewhere in the MSM.
- c. The IC must review the recipient's service plan with the recipient or their PCR prior to the initiation of services. The IC shall review all allowable tasks, excluded activities and recipient back up plan. Documentation must be maintained in the recipient's file that this requirement has been met.

d. 24 Hour Accessibility

The IC should have reasonable phone access either through a cell phone or home telephone for contact by the recipient or PCR. The IC is not required to maintain 24-hour phone accessibility.

e. Backup Mechanism

The IC has no responsibility to establish a back-up mechanism in the event of an unanticipated, unscheduled absence because this is a recipient or PCR responsibility. The IC must notify the recipient at least two (2) weeks in advance of anticipated time off (vacation, elective surgery etc.).

f. Referral Source Agreement

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The IC has no responsibility to establish a referral source agreement as there are no provider agencies within the immediate geographical area.

g. Administrative Functions

The IC ~~must~~ **is responsible for** complying with all state regulations regarding independent contractors.

h. Service Initiation

Prior to initiation of services and periodically as needed, the IC must review with the recipient or PCR, the following:

1. Advanced Directive, including their right to make decisions about their health care, and the right to execute a living will or grant power of attorney to another individual. Refer to MSM Chapter 100 for further information.
2. Procedure to be followed when a PCA does not appear at a scheduled visit or when an additional visit is required.
3. The non-covered service/tasks of the PCS program.
4. The procedure and form used to verify PCA attendance.
5. The recipient's service plan or any changes in the service plan, including the following:
 - a. Authorized service hours;
 - b. PCA's schedule;
 - c. PCA's assigned tasks and pertinent care provided by informal supports; and
 - d. ~~The recipient's back-up plan.~~

i. Supervision

The IC is not required to meet the supervisory requirement of the PCS agency. As an IC the provider is required to perform all PCA services.

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j. Training

The IC may be required to obtain training in the following areas, if directed to do so by the recipient. ~~has 60 days to meet the basic training requirements and to obtain Cardiopulmonary Resuscitation (CPR) certification. Waiver of the basic training requirements may be permitted if the criteria for waiver competency are met. The local District Office may be available to assist with the determination that competency exists. Documentation of completion of the required subject areas must be provided to the local District Office.~~

1. Basic Training - Basic training shall involve community resources, such as public health nurses, home economists, physical therapists, and social workers. An outline of content of each subject shall be maintained by the provider IC.

Basic training shall be a minimum of 16 hours in length. Basic training ~~must~~ may include content in all of the following areas:

- a. Orientation to the service plan, community and the DHCFP medical assistance program services;
- b. Body mechanics and transfer techniques;
- c. Bathing, basic grooming and mobility techniques, including simple non-prescribed range of motion;
- d. Personal care skills, including PCS permitted and not permitted (refer to ~~s~~Sections 2603.1C and 2603.8-3503.1A);
- e. Care of the home and personal belongings;
- f. Infection control, including information on common communicable diseases, blood borne pathogens, infection control procedures, universal precautions and applicable Occupation Safety Hazard Act (OSHA) requirements;
- g. Household safety and accident prevention, including information on general household safety and how to prevent accidents, poisoning, fires etc. and minimizing the risk of falls;
- h. ~~Food~~ Food, nutrition and meal preparation, including information on a well-balanced diet, special dietary needs and the proper handling and storage of food;

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- i. Bowel and bladder care, including routine care associated with toileting, routine maintenance of indwelling catheter drainage system (emptying bag, positioning, etc.), routine care of colostomies (emptying bag, changing bag), signs and symptoms of urinary tract infections, and common bowel problems such as constipation and diarrhea;
- j. Skin care, including interventions to prevent pressure sores, (repositioning, use of moisturizers, etc.), routine inspections of skin, and reporting skin redness, discoloration or breakdown to the recipient or caregiver;
- k. Health oriented record keeping, including written documentation of services provided and time verification records;
- l. Recipient's rights, including confidentiality pursuant to state and federal regulations and consumer rights;
- m. Communication skills, including basic listening and verbal communication skills, problem solving and conflict resolution skills, as well as alternative modes of communication techniques for individuals with communication or sensory impairments;
- n. Information including overview of aging and disability (sensory, physical and cognitive) regarding changes related to the aging process, sensitivity training towards aged and disabled individuals, recognition of cultural diversity and insights into dealing with behavioral issues;
- o. Advance directives, including information regarding the purpose of an advance directive and implications for the PCA. ~~and~~
- p. ~~CPR certification, which may be obtained outside the agency. Online CPR training is insufficient to meet the requirements of this section. PCAs must physically attend and successfully pass a CPR certification training which includes demonstration of competencies in administering CPR. Documentation of current CPR certification must be maintained in each PCA's file by the provider.~~

PCA Employment Standards—Minimum Qualifications

Reference MSM Chapter 3503.1B.17.

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k. Records

The IC must maintain medical and financial records, supporting documents, and all other records relating to PCS provided. The provider must retain records for a period pursuant to the State records retention policy, which is currently six (6) years from the date of payment for the specified service.

l. HIPAA, Privacy, and Confidentiality

Refer to MSM Chapter 100 for information on HIPAA, privacy, and confidentiality of recipient records and other protected health information.

m. Notification of Suspected Abuse or Neglect

Reference **Section 2603.8 of this MSM Chapter.** ~~3503.1B.21~~

~~Prior Authorization~~

~~Prior authorization must be obtained before services can be provided. PCS is authorized by the DHCFP's QIO like vendor. The IC shall obtain prior authorization for all initial and ongoing services.~~

2603.4.3C1D RECIPIENT RESPONSIBILITIES

All of the policies discussed in the ~~MSM Section 3503.1C~~ **2603.9, of this chapter** apply to the IC model.

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26045 HEARINGS

Reference MSM, Chapter 3100 Hearings, for Medicaid recipient **hearing procedures** and **Medicaid** provider hearing procedures.

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26056 SELF DIRECTED (SD) SKILLED SERVICES – CLINICAL DECISION SUPPORT GUIDE

Level I	Level II	Level III	Level IV	Level V
Not to exceed 4 hours a week	Not to exceed 10 hours a week	Not to exceed 22 hours a week	Not to exceed 30 hours a week	Not to exceed 40 hours a week
+ Limited skilled interventions	++ One or two routine skilled interventions, with or without limited skilled interventions.	Three to five routine skilled interventions, with or without limited skilled interventions; or	Four to six routine skilled interventions, with or without limited skilled interventions; or	Seven routine skilled interventions, with or without limited skilled interventions; or
		+++ One highly complex skilled and one to two routine skilled intervention(s), with or without limited skilled interventions; or	One highly complex skilled intervention and three to four routine skilled intervention(s), with or without limited skilled interventions; or	One highly complex skilled intervention and five to six routine skilled interventions, with or without limited skilled interventions; or
		Two complex skilled interventions, with or without limited skilled services.	Two highly complex skilled interventions, with either routine skilled interventions or limited skilled interventions.	Two highly complex skilled intervention and two to five routine skilled interventions, with or without limited skilled interventions; or
				Three highly complex skilled interventions, with or without additional routine skilled interventions or limited skilled interventions.