

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 25, 2019

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: TAMMI MOFFITT, CHIEF OF OPERATIONS
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2600 – INTERMEDIARY SERVICE ORGANIZATION

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2600 – Intermediary Service Organization are being proposed to add language due to the passage of the 21st Century Cures Act. In December 2016, Congress passed H.R. 34 - 21st Century Cures Act, mandating that all States require the use of an Electronic Visit Verification (EVV) system for all Medicaid-funded personal care services that are provided under a State Plan or a waiver of the plan, including services provided under section 1915(c).

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

Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers delivering specific personal care services. Those provider types include, but are not limited to: Intermediary Service Organization (PT 83).

Financial Impact on Local Government: Unknown at this time.

These changes are effective September 25, 2019

<u>MATERIAL TRANSMITTED</u>	<u>MATERIAL SUPERSEDED</u>
CL N/A CHAPTER 2600– INTERMEDIARY SERVICE ORGANIZATION	MTL, 21/16 CHAPTER 2600– INTERMEDIARY SERVICE ORGANIZATION

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2601	AUTHORITY	Added 21 st Century Cures Act mandate and H.R 6042 – 115 th Congress.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2603.1	SELF-DIRECTED PERSONAL CARE SERVICES (PCS)	Clarified that all services must be documented in an approved (EVV) system.
2603.1B	INITIATING SELF-DIRECTED PERSONAL CARE SERVICES (SD PCS)	Removed obsolete form titles.
2603.1F	ELECTRONIC VISIT VERIFICATION (EVV)	New section added to highlight the 21 st Century Cures Act requirements. There are two options in the State of Nevada for use of an EVV system: state option and data aggregator. Various data points are required and outlined in this section.
2603.8	PROVIDER RESPONSIBILITIES	<p>Added the 21st Century Cures Act to the list of local, state and federal regulations that agencies must comply with.</p> <p>Added EVV language to mandate the use of an EVV system for all.</p> <p>Added language that the Intermediary Services Organization staff must review with the recipient, LRI or PCR the EVV requirements and recipient participation to adhere to the 21st Century Cures Act.</p> <p>Added language (ISO) that all PCAs must understand the EVV requirements and expectations, including the documentation of all personal care services in an approved EVV system.</p> <p>Removed language regarding records. All record requirements are listed in the newly created Section 2603.1F.</p>
2603.9	RECIPIENT RESPONSIBILITIES	Added language to agree to utilize a Medicaid-approved EVV system and to confirm services electronically, per requirements of the 21 st Century Cures Act.
2604.IB	PROVIDER RESPONSIBILITIES	Added language to agree to utilize a Medicaid-approved EVV system and to confirm services

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electronically, per requirements of the 21st Century Cures Act.

Added EVV language to mandate the use of an EVV system for services performed through the independent contractor model.

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2601 AUTHORITY

Personal Care Services (PCS) are an optional Medicaid benefit under the Social Security Act (SSA).

Regulatory oversight:

- ~~Social Security Act~~ SSA 1905(a)(24)
- Title 42, Code of Federal Regulations (CFR), Section 440.167
- Nevada State Plan Attachment 3.1-A(26)
- 21st Century Cures Act, H.R. 34, Sec. 12006 – 114th Congress
- H.R. 6042 – 115th Congress

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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.

2603.1 SELF-DIRECTED 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 **and documented in an approved Electronic Visit Verification (EVV) system**. 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.

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 their own care, a PCR may do so on their behalf.

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 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;
3. The recipient does not have an LRI who is available and capable of providing the necessary care;

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4. The recipient must be able to make choices about ADLs, understand the impact of these choices and assume responsibility for them 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 must be cooperative in establishing the need for the provision of services and comply with the approved service plan;
6. PCS must be determined to be medically necessary as defined by the DHCFP or its designee; and
7. The recipient or PCR must be willing and capable of managing all tasks related to service delivery including, but not limited to: recruitment, selection, scheduling, training and directing PCAs.

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

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

1. The DHCFP District Office or local ADSD Office staff provides information to the recipient or the PCR about the self-directed services available. 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).~~
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 Services Unskilled Only Personal Care Representative Agreement. ~~(Form NMO-3437).~~

A signed copy of either agreement should be given to the recipient and/or PCR and the ISO shall retain the original for their records.

2603.1C COVERAGE AND LIMITATIONS

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.

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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 meet recipient requests for changes in service delivery in a timely manner.
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.

2603.1F ELECTRONIC VISIT VERIFICATION (EVV)

The 21st Century Cures Act requires the use of an EVV system to document services that are provided for all personal care services under a Medicaid State Plan or waiver program. This mandate requires provider agencies to use an EVV system to record service delivery visit information. Nevada Medicaid utilizes the open-system model, procuring a vendor but also allows agencies to utilize their own EVV system if it meets the 21st Century Cures Act requirements for documentation.

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All service information must be recorded in an electronic system that interfaces with either a telephone or an electronic device that generates a timestamp. The provider agency must verify the EVV record, including any visit maintenance, prior to submitting a claim associated with the EVV record. All claims must be supported by an EVV entry into an EVV system prior to claim submission.

Provider Agencies must ensure each Personal Care Attendant (PCA) has a unique identifier (National Provider Identification – NPI) associated with their worker profile in the EVV system.

1. STATE OPTION

A. The EVV system electronically captures:

1. The type of service performed, based on procedure code;
2. The individual receiving the service;
3. The date of the service;
4. The location where service is provided;
5. The individual providing the service;
6. The time the service begins and ends.

B. The EVV system must utilize one or more of the following;

1. The agency/PCA's smartphone;
- 1.2. The agency/PCA's tablet;
- 2.3. The recipient's landline telephone;
- 3.4. The recipient's cellular phone (for Interactive Voice Response (IVR) purposes only)
- 4.5. Another GPS-based device as approved by DHCFP.

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2. DATA AGGREGATOR OPTION

A. All Provider Agencies that utilize a different EVV system (as approved by the DHCFP) must comply with all documentation requirements of this chapter and must utilize the data aggregator to report encounter or claim data.

1. Appropriate form must be approved by the DHCFP before use of system to ensure all data requirements are being collected to meet the 21st Century Cures Act.

1.2. At a minimum, data uploads must be completed monthly into data aggregator.

2603.1G CONFLICT OF INTEREST STANDARDS

The DHCFP assures the independence of contracted providers completing the FASPs. Physical and occupational therapists who complete the FASPs 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;
2. financially responsible for the individual;
3. empowered to make financial or health-related decisions on behalf of the individual;
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 individuals 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.

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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 60-day interval in a three-year period (calendar years).

The provider must contact the DHCFP QIO-like vendor with information in writing regarding the crisis situation and need for additional hours.

2603.7D 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 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 Authorization Request for Self-Directed Skilled Services Authorization Form (FA-24C) and all necessary supporting medical documentation specific to the request to the QIO-like vendor for processing.
2. 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.
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.

2603.8 PROVIDER RESPONSIBILITIES

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:

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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.

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).

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

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) **and the 21st Century Cures Act.**

3. Employer of Record

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

4. **Electronic Visit Verification (EVV)**

Utilize an EVV system that meets the requirements of the 21st Century Cures Act, to electronically document the PCS provided to Medicaid recipients served by a Medicaid provider.

5. **4** Recipient Education

The ISO 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 on how to recruit, interview, select, manage, evaluate, dismiss and direct 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.

6. Personal Care Assistant (PCA) List

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The ISO may, upon request, provide a list of PCAs to recipients, their LRI or their PCR. The recipient, their LRI or PCR may reference this list in recruiting potential PCAs.

7. 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 recipient, their LRI or PCR.

8. Backup Plan

The ISO 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. This may include providing a current list of PCAs available to assist in 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 is the responsibility of the recipient, their LRI or PCR.

9. Medicaid and Nevada Check Up (NCU) Eligibility

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

10. 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.

11. Service Initiation

Prior to the start of services, the ISO staff must review and document with the recipient, their LRI or PCR all components of the MSM Chapter 2600 and the following items:

- a. The ISO may initiate education of the recipient or PCR in the skills required to act as managing employer and self-direct care. This may include training on how to recruit, interview, select, manage, evaluate, dismiss and direct the PCAs in the delivery of authorized services. Documentation of this must be maintained in the recipient's file.

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- b. The ISO must review with the recipient, their LRI or PCR the approved service plan, weekly hours, tasks to be provided and ~~required-EVV requirements and recipient participation~~.
- 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.
- d. The ISO provider must review with the recipient, their LRI or PCR the differences between the Agency and the SD Service Delivery Model.

12. PCS Not Permitted

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.

13. Supervision

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

All PCAs must understand the EVV requirements and expectations, including the documentation of all personal care services in an approved EVV system.

14. Provider Liability

Provider liability responsibilities are included in the Medicaid and NCU Provider Contract.

13.15. Notification of Suspected Abuse or Neglect

State law requires that persons employed in certain capacities 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 believe that a child, adult or older person has been abused, neglected, exploited, isolated or abandoned.

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.

16. Serious Occurrences

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;

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- 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.

17. ~~Health Insurance Portability and Accountability Act (HIPAA), Privacy and Confidentiality~~

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

18. Direct Marketing

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

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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.

18.19. Records

The provider must maintain medical and financial records, supporting documents, and all other records relating to services provided. The provider must retain records for a period pursuant to the State records retention policy, which is currently six 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~~

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~~the PCA and that services were provided in accordance with the approved service plan.~~

- b. 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.

20. 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 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.

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.

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- 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.

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 year.

2603.9 RECIPIENT 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, 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.
- d. treat all staff appropriately.
- ~~e.~~ agree to utilize an approved EVV system for the Medicaid services being received from the ISO.
- ~~e.f.~~ confirm services were provided by electronically signing or initialing, as appropriate per service plan, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

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- ~~f.g.~~ establish a backup plan in case a PCA is unable to provide services at the scheduled time.
- ~~g.h.~~ not request a PCA to work more than the hours authorized on the approved service plan.
- ~~h.i.~~ not request a PCA to work or clean for non-recipients.
- ~~i.j.~~ not request a PCA to provide services not on the approved service plan.
- ~~k.~~ _____comply with all Medicaid policies and procedures as outlined in the MSM, all relevant chapters, including Chapters 100 and 3300.
- ~~l.~~ _____recruit, interview, select, schedule, direct and dismiss PCAs.
- ~~m.~~ develop a backup plan in the event of failure to maintain continuous coverage of regularly scheduled PCAs.
- ~~n.~~ 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.
- ~~o.~~ inform the PCA of the existence of advance directive documents, if these are available, and provide a copy to the ISO, if appropriate.
- ~~p.~~ 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 request care be provided through a provider agency.
- ~~q.~~ cooperate with the DHCFP or its designee in conducting compliance reviews, investigations or audits.
- ~~r.~~ specify any and all specialized training requirements of the PCA and assure that the specified training has been received.
- ~~s.~~ obtain re-certification for continued services according to policy. This may require that a FASP and/or a new authorization request for Self-Directed Skilled Services Form 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.

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- t. 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.
- ~~u.~~ 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.
- v. 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;
- 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;

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2604 PCS INDEPENDENT CONTRACTOR (IC) MODEL

An individual may independently contract with the DHCFP 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 PCS IC when the need and preference for SD Skilled Services exists, where no PCS Agency 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 application to become an IC with Nevada Medicaid is made through the local DHCFP District Office. Each IC providing PCS must comply with all PCS program criteria. The local DHCFP District Office will inform the potential IC of program criteria, training requirements, etc. The local DHCFP District Office will assist in processing the IC’s application which must be submitted to the QIO-like vendor. Once the IC is approved, the local DHCFP District Office will notify the appropriate ADSD case manager who will provide the IC with the recipient’s service plan and authorized service hours.

2604.1 COVERAGE AND LIMITATIONS

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

2604.1A 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.

2604.1B 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.

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 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.

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2. **Electronic Visit Verification (EVV)**
Utilize an EVV system that meets the requirements of the 21st Century Cures Act, to electronically document the PCS provided to Medicaid recipients served by a Medicaid provider.

~~2.3.~~ 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 weeks in advance of anticipated time off (vacation, elective surgery etc.).

f. 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.

g. Administrative Functions

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

h. Service Initiation.

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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

6. EVV requirements and recipient participation.

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 **and document all services in an approved EVV system.**

j. Training

The IC may be required to obtain training in the following areas, if directed to do so by the recipient.

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 IC.