MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 13, 2011

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

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

BACKGROUND AND EXPLANATION

Revisions to MSM Chapter 2600 are made to remove process or procedural barriers to recipient choice of self-direction, removing the requirement for DHCFP District Office staff to assess the recipient or Personal Care Representative's ability to understand and comply with the Self-Directed Model.

Additionally, language regarding "significant change" has been clarified to reflect "significant change in condition or circumstance".

Further revisions remove the Definitions and References/Cross References sections, from this Chapter to the Medicaid Services Manual Addendum to be consistent with other MSM Chapters.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, acronyms used and standardized, and the acronym DO was reverted back to District Office for consistency.

These changes are effective December 14, 2011.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 37/11 CHAPTER 2600 – INTERMEDIARY SERVICE ORGANIZATION	MTL 06/10, 30/10 CHAPTER 2600 – INTERMEDIARY SERVICE ORGANIZATION

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2602	**Reserved**	Removed Definition Section.
2603.1	**Self-Directed (SD) Model**	Removed process or procedural barriers to recipient choice of self-direction, specifically the responsibility of District Office staff to assess the recipient or Personal Care Representative's ability to understand and comply with the Self-Directed

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Model. Revises responsibility for form initiation, distribution, processing and retention and language regarding significant change to significant change in condition or circumstances. Corrects NMO form number from 3234 to 3432.
2605	**Clinical Decision Guide**	Removed References and Cross References section and renamed.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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2600 INTRODUCTION

INTERMEDIARY SERVICE ORGANIZATION - (ISO)

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 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.

2601 AUTHORITY

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

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).

2602 RESERVED

2603 POLICY

An Intermediary Service Organization (ISO) is an entity acting as an intermediary between Medicaid recipients, who elect the Self-Directed 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 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 DHCFP's 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 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

The Self-Directed (SD) Model is a service delivery option which allows the recipient to direct their own personal care. Services under the personal care optional benefit 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) 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. All individuals seeking this type of self-directed program will require prior authorization from DHCFP District Office staff, normally a care coordinator, or in the case of an Aging and Disability Services Division (ADSD) recipient, from the ADSD care coordinator.

a. SELF-DIRECTED MODEL INITIATION

The recipient or PCR indicates interest in the Self-Directed Model by contacting the DHCFP or ADSD District Office directly.

1. DHCFP or ADSD District Office staff provides information to the recipient or the PCR about the Self-Directed 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.

2. The ISO will provide and the recipient will sign Form NMO-3434, ISO Self Directed PCS – Unskilled Only PCR Agreement, or if the PCR is directing the recipient's care, the PCR will sign Form NMO-3437, ISO Self Directed PCS – Unskilled Only PCR Agreement. A copy of either form will be sent to the QIO-like vendor and the ISO shall retain the original for their records.

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

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

5. 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. The QIO-like vendor notifies the appropriate DHCFP or ADSD District Office when the provider requests annual recertification and/or when a significant change in condition or circumstances occurs.

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.

2603.1A 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. PERSONAL CARE REPRESENTATIVE (PCR)

A recipient who is unable to direct their own services may opt to utilize a PCR. This individual directs the day-to-day care of the recipient, hires, manages and schedules personal assistants, assumes responsibility for training, and manages all paperwork functions. In addition, the PCR assumes all medical liability associated with directing the recipient's care. The PCR must:

a. effectuate, as much as possible, the decision the individual would make for himself/herself;

b. accommodate the individual, to the extent necessary that they can participate as fully as possible in all decisions that affect them;

c. give due consideration to all information including the recommendations of other interested and involved parties; and

d. embody the guiding principles of self-determination.

A PCR is not eligible to receive reimbursement from Medicaid for this activity. A PCR cannot be the recipient's paid personal care assistant. The PCR must meet all criteria outlined in Section 2603.1C of this chapter. In addition, this individual must be 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 care coordinator or an employee of an agency to assume this role.

2. PROGRAM ELIGIBILITY CRITERIA

a. The recipient or the PCR must be capable of making choices about activities of daily living, 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.

c. 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.

2603.1B PROVIDER RESPONSIBILITY

The following policies apply to ISO's under the Self-Directed Model.

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

2. 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).

a. Provider Enrollment

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 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 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 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 DHCFP named as an additional insured.

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 FBI criminal background checks, as identified in this section. ISO owners, officers, administrators, management and employees must undergo an FBI criminal background check as described in this section 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 tuberculosis testing requirements of this section and are consistent with 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;

   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. EMPLOYER OF RECORD

The ISO is the employer of record for PCAs providing services to Medicaid recipients who choose this Self-Directed model.

4. CRIMINAL BACKGROUND CHECKS

Under NRS 449.176 through NRS 449.188, individuals who have been convicted of certain crimes may not work at certain long term care facilities or agencies. The complete statute is available at http://leg.state.nv.us/NRS/NRS-449.html and the requirements applying to ISO Agencies are discussed at length at the Bureau of Health Care Quality and Compliance (HCQC) website: http://health.nv.gov/HCQC_CriminalHistory.htm.

All agency personnel, including owners, officers, administrators, managers, employees and consultants must undergo State and FBI background check upon certification as an ISO by the ADSD and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred.

Documentation of the request and applicable results must be maintained in each employee personnel record and made available to DHCFP upon request. Employees must have the criminal background check through the Nevada Department of Public Safety (DPS) initiated by the hiring/employing agency prior to providing any Medicaid reimbursable services to a recipient.

Providers are required to initiate diligent and effective follow up for results of background checks within ninety (90) days of submission of prints and continue until results are received including when an "undecided" result is received. Documentation must be maintained in the employee's personnel file and submitted to DHCFP upon request.

a. The DHCFP or their designee will not enroll any person or entity convicted of a felony or misdemeanor for any offense which the State agency determines is inconsistent with the best interests of recipients. Such determinations are solely the responsibility of DHCFP.

b. The DHCFP applies the requirements of NRS 449.176 through NRS 449.188 and will deny a provider contract to any applicant, or may suspend or revoke all associated provider contracts of any provider, to participate in the Medicaid program if the requirements of the referenced NRS sections are not met. In addition, see MSM Chapter 100.

1. If the Provider receives information related to NRS 449.176 through NRS 449.188 resulting from the criminal background check or from any other source and continues to employ a person who has been convicted of an offense as listed above, DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.

2. If the hiring/employing agency does not take timely and appropriate action on the results of the background check as defined in NRS 449.176 through NRS 449.188 and on the HCQC website, DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.

c. If an employee believes information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency and DHCFP in writing. Information regarding challenging a disqualification is found on the HCQC website at: http://health.nv.gov/HCQC_CriminalHistory.htm.

5. TUBERCULOSIS TESTING

PCAs must complete either a QuantiFERON®-TB Gold blood test (QFT-G) or a two step (TB) Tuberculin skin test prior to initiation of services for a Medicaid recipient. Thereafter, each PCA must receive a QFT-G blood test or one step TB skin test annually, prior to the expiration of the initial test. If the PCA has a documented history of a positive QFT-G or TB skin test (+10 mm induration or larger), the PCA must have clearance by a chest X-ray prior to initiation of services for a Medicaid recipient.

If the PCA has been medically cleared after a documented history of a positive QFT-G or TB skin test which was 10 mm or larger and then by chest X-ray, the PCA must have documentation annually which demonstrates no signs or symptoms of active tuberculosis.

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 tuberculosis.

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, 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

The ISO must educate the recipient or PCR in the skills to act as managing employer. This includes tasks related to selecting, managing, 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. PCA LIST

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

8. BACKUP LIST

The ISO shall maintain and make available to the recipient 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, because this is a recipient 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.

11. BACKUP PLAN

The ISO is required to assist the recipient in developing a written back-up plan to address personal care service needs in the event that care is interrupted. This includes making a current copy of the PCA list available to assist in developing 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, 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.

13. MEDICAID AND NEVADA CHECK UP (NCU) ELIGIBILITY

Verification of Medicaid or NCU eligibility is the responsibility of the ISO.

14. SERVICE INITIATION

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

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

b. The ISO must review with the recipient the service plan, allowable hours, tasks and required paperwork.

c. The ISO must review with the recipient 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 or PCR the differences between the Agency model and the Self-Directed Model.

15. PCS NOT PERMITTED

Reference MSM 3503.1B.15.

16. SUPERVISION

The ISO must review and document with the recipient or PCR, their approved service plan. This must be done each time a new service plan is implemented. The supervisor must clarify with the recipient or PCR, their needs and the tasks to be performed.

17. PROVIDER LIABILITY

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

18. 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 or law enforcement agency immediately, but in no event later than twenty-four (24) hours after there is reason to suspect a minor child has been abused or neglected. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

For recipients under the age of eighteen (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 sixty (60) and over, the ADSD accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

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. 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.

20. SERIOUS OCCURRENCES

Reference MSM Section 3503.1B.20.

21. TERMINATION OF SERVICES

Reference MSM Section 3503.1B.22.

22. HIPAA, PRIVACY, AND CONFIDENTIALITY

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

23. DIRECT MARKETING

Reference MSM Section 3503.1B.12.

24. CONFLICT OF INTEREST

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

25. RECORDS

The provider 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.

2603.1C RECIPIENT/PERSONAL CARE REPRESENTATIVE (PCR) RESPONSIBILITIES

1. 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 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 personal representatives;

d. treat all staff appropriately;

e. 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;

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

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

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

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

2. In addition, the following policies apply to the Self-Directed Model. The recipient or PCR must:

   a. Sign all forms related to the Self-Directed option provided by the local DHCFP District Office and the QIO-like vendor as appropriate;

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

   c. 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. Develop a backup plan in the event of failure to maintain continuous coverage of regularly scheduled PCAs;

   f. 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 in section 2602 regarding signature or initial requirements.) Misrepresentation within this process constitutes fraud per NRS 422.540 and NRS 422.550.

   g. Inform the PCA of the existence and location of advance directive documents, if these are available;

   h. Notify the ISO and the local DHCFP District Office to request care through a provider agency;

   i. Cooperate with the DHCFP or its designee in conducting compliance reviews, investigations, or audits;

   j. Specify any and all specialized training requirements of the PCA and assure that the specified training has been received.

   k. Obtain re-certification for continued services according to regulation. This will require that a functional assessment, service plan, and all forms associated with self-direction of services be completed.

   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

The policies discussed in the MSM Section 3503.1E, apply to the Self-Directed Model.

2603.2 SELF-DIRECTED SKILLED SERVICES

Self-Directed Skilled Services are a covered benefit under a Self-Directed 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 SKILLED SERVICES INITIATION

The recipient or their PCR indicates interest in the Self-Directed Skilled Services Model by contacting the DHCFP District Office directly.

1. DHCFP or ADSD District Office staff assesses the recipient's or the PCR's ability to understand and comply with the Self-Directed Skilled Services Model.

2. The recipient signs Form NMO-3245, ISO Self Directed 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 Self Directed Specific Medical, Nursing or Home Health Care Services Personal Representative Agreement form.

3. DHCFP or ADSD District Office staff forwards Form NMO-3234, ISO Authorization Request, along with either Form NMO-3435 or Form NMO-3436 to the QIO-like vendor.

4. 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.

5. 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. The QIO-like vendor notifies the

appropriate DHCFP or ADSD District Office when the provider requests annual recertification and/or when a significant change occurs.

2603.2A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

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 Self-Directed Skilled Services:

a. The primary physician has determined the condition of the person with a disability is stable and predictable;

b. 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;

c. A provider of healthcare has determined the personal care assistant has the knowledge, skill and ability to perform the services competently;

d. The personal care assistant 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

e. 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. COVERED SERVICES

a. Self-Directed Skilled Services may be approved for recipients who are chronically ill or disabled who require skilled care to remain at home.

b. The services are medically necessary and required to maintain or improve the recipient's health status.

c. 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. The service or services must be sufficient in amount, duration and scope to reasonably achieve its purpose.

e. All services must have prior authorization.

3. 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 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 medications on a different frequency schedule, administration of edications

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 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 2605.3. 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 Self-Directed 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) sixty (60) day interval in a three year period (calendar years).

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. Self-Directed Skilled Services provided in the absence of a parent or guardian for those individuals who are not able to direct their own care; or

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

2603.2B PROVIDER RESPONSIBILITIES

The intent of Self-Directed 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 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 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 DHCFP.

2603.2C RECIPIENT RESPONSIBILITIES

The intent of Self-Directed 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 Self-Directed Skilled Services:

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. 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. Self-Directed Skilled Services are authorized by DHCFP's QIO-like vendor. Services must be requested using code T1019 plus a TF modifier to represent Self-Directed Skilled Services.

If the TF modifier is not requested, reimbursement for Self-Directed 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 Self-Directed 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.

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.

2603.3 PCS INDEPENDENT CONTRACTOR (IC) MODEL

A PCA may independently contract with DHCFP in accordance with Chapter 100 to provide Self-Directed 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 DHCFP to become a PCA Independent Contractor (IC) when the need and preference for Self-Directed Skilled Services exists, where no PCR or ISO is available and when the absence of an Independent Contractor would constitute a hardship for an eligible recipient. A hardship situation is one in which the recipient is considered to be "at risk" as defined in Section 2602 of this chapter.

PCS Application to become an IC is made through the local DHCFP DO. Each IC providing PCS services must comply with all PCS program criteria. The local DHCFP District Office will inform the potential PCA Independent Contractor of program criteria, training requirements, etc. The local DHCFP 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 DHCFP District Office care coordinator 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.

2603.3A COVERAGE AND LIMITATIONS

All of the policies discussed in the MSM Section 3503.1A apply to the Independent Contractor option.

2603.3B PROVIDER RESPONSIBILITIES

The Independent Contractor (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 Self-Directed Skilled Services pursuant to NRS 629.091. Each IC providing PCS and Self-Directed Skilled Services must comply with PCS program criteria.

In order to ensure the safety and well-being of the recipient, documentation specific to the Self-Directed 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 DHCFP or the QIO-like vendor.

1. PROVIDER ENROLLMENT

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

a. Tax ID number.

b. Proof of FBI Background Check.

c. Documentation specific to the Self-Directed Skilled Services option.

The following policies apply to the Independent Contractor option:

d. The IC must verify Medicaid Eligibility monthly.

e. 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. 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. 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. 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. 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. Administrative Functions

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

k. 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.

l. Supervision

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

m. Training

The IC has sixty (60) days to meet the basic training requirements and to obtain 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 DO.

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 sixteen (16) hours in length. Basic training must include content in all of the following areas:

   a. orientation to the service plan, community and 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 section 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 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, nutrition and meal preparation, including information on a well balanced diet, special dietary needs and the proper handling and storage of food;

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.

n. PCA Employment Standards – Minimum Qualifications

Reference MSM Chapter 3503.1B.17.

o. Records

The independent contractor 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. 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

Prior authorization must be obtained before services can be provided. PCS is authorized by 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 Independent Contractor model.

2603.3D AUTHORIZATION PROCESS

All of the policies discussed in the MSM Section 3503.1E, apply to the Independent Contractor option.

2603.4 ESCORT SERVICES

All of the policies discussed in MSM Section 3503.8 apply.

2603.5 TRANSPORTATION

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 DHCFP. Recipients who choose to be transported in Provider or PCA vehicles do so at their own risk.

2603.6 QUALITY ASSURANCE

DHCFP will conduct an annual review to assure the health, welfare and satisfaction with services and freedom of choice of the recipients served by these programs. Additionally, a review 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 claims are paid in accordance with the State Plan and all federal and state regulations. Providers must cooperate with DHCFP's annual review process.

Reviews will consist of but are not limited to, a pre-audit review of information to be submitted to 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 DHCFP to determine program quality and recipient satisfaction.

2604 HEARINGS

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

2605 SELF DIRECTED 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.