MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 11, 2012

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE M. Stagliano

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3500 – PERSONAL CARE SERVICES (PCS) PROGRAM

BACKGROUND AND EXPLANATION

Revisions have been made to MSM Chapter 3500, PCS, to the criminal background check references to clarify the compliance requirements of the Bureau of Health Care Quality and Compliance (HCQC) and to follow MSM Chapter 100 provider enrollment requirements.

The Tuberculosis (TB) Testing Section has been revised to match the current language of Nevada Administrative Code (NAC) 441A.375. Language has been updated to cover TB testing requirements for potential and ongoing Personal Care Attendant (PCA) employees.

The requirement that individual case managers for recipients on the 1915(c) waiver complete the Service Plan and authorize services for PCS has been removed. This function is now completed by the Quality Improvement Organization (QIO)-like vendor.

Language was clarified that recipients have the option of selecting a Medicaid enrolled and trained physical or occupational therapist for completion of their functional assessment. The QIO-like vendor will assign a provider if no preference is specified.

Currently the chapter lists assistance with self-administered medications as a covered service under Activities of Daily Living (ADLs). However, section 1915(i)(1)(F) of the Social Security Act (Act) defines ADLs in terms of section 7702B(c)(2)(B) of the Internal Revenue Code of 1986, which includes the following: bathing, dressing, toileting, transferring, eating and continence.

In order to be in compliance with the Act, assistance with self-administered medications is being removed as a covered service through the standard delivery model of PCS because it does not meet the definition of an ADL. Recipients who require assistance with self-administered medications may access this service through the Intermediary Service Organization model of self directed care. Please refer to MSM Chapter 2600.

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

These policy changes are effective September 12, 2012.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 22456 / CL 23034 CHAPTER 3500 – PERSONAL CARE SERVICES PROGRAM	MTL 11/11 CHAPTER 3500 – PERSONAL CARE SERVICES PROGRAM

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3503.1A.2	**Personal Care Services (PCS) – Coverage and Limitations – Covered Services**	Deleted "Assistance with medications which are self administered, including verbal reminders to the recipient to take medications, bringing medication to the recipient and loosening the cap to the medication container. Medication Administration by a Personal Care Attendant is not permitted."
3503.1B.1	**PCS – Provider Responsibility – Provider Enrollment**	Deleted language for criminal background check compliance as referenced in 3503.1B.3.
3503.1B.3	**PCS – Provider Responsibility – Criminal Background Checks**	Added language for criminal background checks completed through the Department of Public Safety, clarification of provider enrollment requirements and made reference to MSM Chapter 100 for additional information. Deleted language duplicative of HCQC licensing requirements.
3503.1B.4	**PCS – Provider Responsibility – Tuberculosis (TB) Testing**	Revised TB testing language to match Nevada Administrative Code 441A.375.
3503.1B.12	**PCS – Provider Responsibility – Direct Marketing**	Deleted duplicative language of Physical Therapist/ Occupational Therapist performing Functional Assessments.
3503.1E.1.a	**PCS – Authorization Process – Prior Authorization – Initial Requests**	Deleted requirement that waiver case managers complete Functional Assessments on waiver recipients. Added language that recipients have the option of selecting a physical or occupational therapist for completion of their functional assessment.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3503.1E.1.b	**PCS – Authorization Process – Prior Authorization – At-Risk Recipient Requests**	Added language that recipients have the option of selecting a physical or occupational therapist for completion of their functional assessment.
3503.1E.3	**PCS – Authorization Process – Changes to Service Plans**	Corrected the word "or" to "and" that short-term modifications of a service plan must be sent to the QIO-like vendor and the appropriate Home and Community-Based Waiver (HCBW) case manager.
3503.10	**Quality Assurance**	Grammar corrections. Not policy changes.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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3500 INTRODUCTION

PERSONAL CARE SERVICES (PCS)

The Nevada Medicaid Personal Care Services (PCS) objective is to assist, support, and maintain recipients living independently in their homes. PCS are also provided in settings outside the home, including employment sites. These services are provided where appropriate, medically necessary and within service limitations. PCS include a range of human assistance provided to persons with disabilities and chronic conditions of all ages, which enables accomplishment of tasks persons with disabilities and chronic conditions would normally do for themselves if they did not have a disability or chronic condition. Services are available to recipients who are not inpatients or residents of a hospital, Nursing Facility (NF), Intermediate Care Facility for the Mentally Retarded (ICF/MR) or institution for mental disease or other excluded settings as identified in this Chapter.

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. All providers must be contracted with the Division of Health Care Financing and Policy (DHCFP) in accordance with Medicaid Services Manual (MSM) 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.

3501 AUTHORITY

Personal Care Services (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 (NF), Intermediate Care Facility for the Mentally Retarded (ICF/MR) 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.

Regulatory oversight is found in Title XIX 42 CFR, 440.167 of the Code of Federal Regulations.

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

3502 RESERVED

3503 POLICY

3503.1 PERSONAL CARE SERVICES (PCS)

All services must be performed in accordance with a written service plan approved by the Division of Health Care Financing and Policy (DHCFP), or its designee, developed in conjunction with the recipient or their representative, and based on the needs of the recipient being served as determined by a Functional Assessment (FA). 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.

This optional Medicaid benefit of PCS is offered under the Provider Agency service model.

3503.1A COVERAGE AND LIMITATIONS

1. Program Eligibility Criteria

   a. The recipient has ongoing Medicaid or Nevada Check Up (NCU) eligibility for services;

   b. The recipient is not in a hospital, Nursing Facility (NF), Intermediate Care Facility for the Mentally Retarded (ICF/MR), an institution for the mentally ill or a licensed group home facility;

   c. The recipient does not have a Legally Responsible Individual (LRI) who is able and capable of providing the necessary care;

   d. The recipient or Personal Care Representative (PCR) must be cooperative in establishing the need for the provision of services and comply with the approved service plan;

   e. The recipient is capable of making choices about ADLs or has a PCR who assumes this responsibility; and

f. PCS must be determined to be medically necessary as defined by the DHCFP or its designee.

2. Covered Service:

a. Assistance with the normal ADLs as described below:

1. Assistance with bathing/dressing/grooming.

2. Assistance with toileting needs and routine care of an incontinent recipient.

3. Assistance with transferring and positioning non-ambulatory recipients from one stationary position to another, including adjusting/changing recipient's position in a bed or chair.

4. Assistance with ambulation, which is the process of moving between locations, including walking or helping the recipient to walk with support of a wheelchair, walker, cane or crutches, assisting a recipient out of bed, chair or wheelchair.

5. Assistance with eating, including cutting up food. Specialized feeding techniques may not be used.

b. The following IADLs are covered services when no LRI is able and capable. Services must be directed to the individual recipient and related to their health and welfare. See Section 3503.1A.3 in this Chapter for specific eligibility criteria.

1. Meal preparation: Service includes storing, preparing and serving food.

2. Laundry: Services include washing, drying and folding the recipient's personal laundry and linens (sheets, towels, etc.) Ironing is not a covered service.

3. Light housekeeping: Services might include changing the recipient's bed linens, dusting, or vacuuming the recipient's living area.

4. Essential shopping: for prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and nutrition of the recipient.

3. Service Limitations

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

a. The recipient has extensive impairments, Level 2 or higher on the FA in two or more areas of ADLs; and

b. The recipient has at least one of the deficits listed below:

1. Mobility deficits/impairments of an extensive nature which requires the use of an assistive device, and directly impact the recipient's ability to safely perform household tasks or meal preparation independently;

2. Cognitive deficits directly impacting the recipient's ability to safely perform household tasks or meal preparation independently;

3. Endurance deficits directly impacting the recipient's ability to complete a task without experiencing substantial physical stressors; or

4. Sensory deficits directly impacting the recipient's ability to safely perform household tasks or meal preparation independently.

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

4. Non-Covered Services

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

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

a. A task that the DHCFP or its designee determines could reasonably be performed by the recipient.

b. Services normally provided by a LRI.

c. Any tasks not included on the recipient's approved service plan.

d. Services to maintain an entire household, such as cleaning areas of the house not used solely by the recipient(s).

e. Services provided to someone other than the intended recipient.

f. Care requiring the technical or professional skill that State statue or regulation mandates must be performed by a health care professional licensed or certified by the State.

g. Chore services including interior and exterior maintenance and yard work.

h. Companion care, baby-sitting, supervision, or social visitation.

i. Care of pets except in cases where the animal is a certified service animal.

j. Respite care intended primarily to relieve a member of the recipient's household, a family member, or caregiver from the responsibility of caring for the recipient.

k. A task the DHCFP determines is within the scope of services provided to the recipient as part of an assisted living contract, a supported living arrangement contract or a foster care agreement.

l. Escort services for social, recreational or leisure activities.

m. Any other service not listed under Section 3503.1.A.2.

5. Adverse Actions

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

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

a. the recipient is not eligible for Medicaid;

b. the recipient does not meet the PCS eligibility criteria;

c. the recipient or their personal care or legal representative refuses services or is non-cooperative in the establishment or delivery of services;

d. the recipient, the PCR, or the recipient's legal representative refuses to accept services in accordance with the approved service plan;

e. all or some services are no longer necessary as demonstrated by the FA;

f. the recipient's needs can be met by a LRI;

g. the recipient's parent and/or legal guardian is responsible for the maintenance, health care, education and support of their child;

h. services requested exceed service limits;

i. services requested are non-covered benefits. (Refer to 3503.1A 4a through m); or

j. another agency or program provides or could provide the services.

3503. 1B PROVIDER RESPONSIBILITY

PCS providers shall furnish qualified PCAs to assist eligible Medicaid and NCU recipients with ADLs and IADLs, as identified on the individual recipient's approved service plan and in accordance with the conditions specified in this Chapter and the Medicaid Provider Contract.

An agency employee who has not met all of the requirements of this Section is not qualified to provide services to Nevada Medicaid recipients.

Any agency permitting an unqualified paid PCA to provide services to a Nevada Medicaid recipient is in violation of the provider agreement and subject to all actions available, including but not limited to discontinuation of the provider agreement and/or full recoupment of monies paid as discussed in Section 3503.1E.7 Improper Billing Practices.

LRIs may not be reimbursed for providing PCS. The LRI must provide verification 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 documentation may be required on a case-by-case basis. Without this verification, PCS will not be authorized.

The Provider must meet the conditions of participation as stated in the Medicaid Services Manual (MSM) Chapter 100.

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

1. 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 the DHCFP, or its designee, at the time of application and upon request. Approval as a Nevada Medicaid provider of PCSs is issued once these requirements are completed and verified.

a. Administrative Requirements - Verification of compliance with these administrative requirements must be provided to the Quality Improvement Organization (QIO)-like vendor at the time of application, at time of contract renewal and at any time upon request.

1. A license to operate a PCS agency issued by the Bureau of Health Care Quality and Compliance (HCQC).

a. Licensure by HCQC requires compliance with Nevada Revised Statute (NRS) 449.176 through NRS 449.188. People who have been convicted of certain crimes may not work at certain long term care facilities or agencies, including agencies to provide PCS in the home.

2. A fixed business landline telephone number published in a public telephone directory. The sole availability of a cell telephone or facsimile line does not meet this requirement.

3. A business office accessible to the public during established and posted business hours.

4. Tax identification name and number (e.g. W-9, SS4).

5. Workers' compensation insurance for all PCAs employed by the provider.

6. Nevada Department of Public Safety (DPS) account for criminal background checks.

7. Commercial general liability insurance of not less than $2,000,000 general aggregate and $1,000,000 each occurrence, with the DHCFP named as an additional insured.

8. 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.

9. Commercial crime insurance for employee dishonesty, with minimum limit required of $25,000 per loss, with the DHCFP named as an additional insured.

   a. 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 their designee at the provider's physical address and must include:

      1. written policies and procedures for compliance with service delivery, including: service initiation, verification of recipient eligibility, supervisory requirements and verification of service provision, as required in this Section.

      2. written policies and procedures for initiating and complying with the requirements for State and Federal Bureau of Investigation (FBI) criminal background checks, as identified in this Section. Agency owners, officers, administrators and management doing business in the State of Nevada must undergo State and FBI criminal background checks to meet the requirements of obtaining licensure through the HCQC and must provide documentation of such prior to approval of a provider application and upon request.

      3. written policies and procedures for compliance with the tuberculosis testing requirements of this Section and consistent with Nevada Administrative Code (NAC) 441A.375.

      4. written policies and procedures for compliance with the provision of 24-hour accessibility as required in this Section.

5. written policies and procedures for compliance with the provision of backup services as required in this Section.

6. written referral source agreement and written policies and procedures for utilizing such agreement, as required in this section.

7. 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.

2. Time Parameters

The Provider will implement PCS in a timely manner. The Provider agrees to furnish qualified staff to provide PCS to eligible Medicaid recipients within five (5) working days of an accepted referral and within twenty-four (24) hours of an accepted referral if the recipient is identified as "at risk" by the DHCFP or its designee.

3. Criminal Background Checks

Under NRS 449.176 through NRS 449.188, people 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 PCS Agencies are discussed at length at the HCQC website: http://health.nv.gov/HCQC_CriminalHistory.htm.

All agency personnel, including owners, officers, administrators, managers, employees and consultants doing business in the State of Nevada must undergo a State and FBI background check per HCQC licensure requirements (documented in NRS 449.176 through NRS 449.188) as a PCS agency and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred and the safety of recipients is not compromised.

Criminal background checks must be conducted through the DPS. Agencies do not have to have a DPS account. Individuals may request their own personal criminal history directly from DPS and the FBI and must have the results sent directly to the employer. Information and instructions may be found on the DPS website at: http://nvrepository.state.nv.us/criminal/forms/PersonalNevadaCriminalHistory.pdf.

The employer is responsible for reviewing the results of employee criminal background checks and maintaining the results within the employee's personnel records. Continued employment is at the sole discretion of the servicing agency. However, the DHCFP has determined certain felonies and misdemeanors to be inconsistent with the best interests of recipients. The employer should gather information regarding the circumstances surrounding the conviction when considering ongoing employment and have this documented in the employee's personnel file. These convictions include (not all inclusive):

a. murder, voluntary manslaughter or mayhem;

b. assault with intent to kill or to commit sexual assault or mayhem;

c. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;

d. abuse or neglect of a child or contributory delinquency;

e. a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in NRS 454;

f. a violation of any provision of NRS 200.700 though 200.760;

g. criminal neglect of a patient as defined in NRS 200.495;

h. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;

i. any felony involving the use of a firearm or other deadly weapon;

j. abuse, neglect, exploitation or isolation of older persons;

k. kidnapping, false imprisonment or involuntary servitude;

l. any offense involving assault or battery, domestic or otherwise;

m. conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;

n. conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; or

o. any other offense that may be inconsistent with the best interests of all recipients.

Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. This is particularly important when an "undecided" result is received. If an employee believes that the information provided in the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the DPS website at: http://dps.nv.gov under Records and Technology.

p. 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. Additional information may be found in MSM Chapter 100, Section 102.2.

4. Tuberculosis (TB) Testing

Before initial employment, a PCA must have a:

a. Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and

b. Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination.

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

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

A person who demonstrates a positive tuberculosis screening test shall submit to a chest x-ray and medical evaluation for 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 three (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 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.

5. 24 Hour Accessibility

The Provider shall maintain 24 hour, seven (7) days per week landline telephone contact availability for recipient contact.

6. Backup Mechanism

The Provider shall have documentation that demonstrates a backup mechanism to staff authorized service hours to recipients in the absence of a regular caregiver due to sickness, vacation or any unscheduled event.

7. Referral Source Agreement

The Provider shall maintain, and utilize as necessary, written referral source agreements with other DHCFP contracted PCS-provider agencies or Home Health Agencies to ensure continuity of care and service coverage for any at risk recipients (on a prospective or back-up basis), who cannot be timely served by the Provider in order to reasonably avoid institutionalization or serious injury to the recipient.

8. Prior Authorization

The Provider shall obtain prior authorization for services. All initial and ongoing services must be prior authorized by DHCFP or its designee. The prior authorization requirements are discussed later in this Chapter. Services which have not been prior authorized will not be reimbursed.

9. Quality Assurance

The Provider shall conduct an annual recipient satisfaction survey and utilize the results to improve services. The annual date is established based on the date the DHCFP provider contract is effective. Results of the agency survey will be made available to the DHCFP or its designee upon request.

10. Provider Liability

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

11. Employee Covenants

The Provider may not impose covenants not to compete upon its PCA employees, and should not bar any PCA from maintaining employee status with any other PCS Provider.

12. Direct Marketing

Providers shall not engage in any unsolicited direct marketing practices with any current or potential PCS recipient. 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 a specific recipient(s).

The agency may not distribute, in any manner, marketing materials related to PCS without written approval of the DHCFP. This includes any substantial updates of previously approved materials. Telephone number, address corrections, contact person changes, typographic error corrections, and similar corrections are not substantive in nature, and do not require re-review by the Division. The DHCFP staff will respond in writing within ten (10) working days of a provider's written request for marketing material review. The agency may not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

The agency must provide the methods by which it intends to assure the DHCFP that marketing, including plans and materials, are accurate and do not mislead, confuse or defraud current or potential recipients. Statements considered inaccurate, false or misleading include, but are not limited to, any assertion or statement that:

a. the recipient must enroll with the agency in order to obtain benefits or in order not to lose benefits; or

b. the agency is endorsed, certified, or licensed by DHCFP. Compensation or incentives of any kind which encourage a specific recipient to transfer from one provider to another are strictly prohibited.

13. Medicaid and NCU Eligibility

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

14. Service Initiation

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

a. Advanced Directive, including the right to make decisions about 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.

b. The agency's program philosophy and policies including:

1. hiring and training of PCA staff;

2. agency responsibilities;

3. providing recipient assistance;

4. complaint procedure and resolution protocols;

5. procedure to be followed if a PCA does not appear at a scheduled visit or when an additional visit is required;

6. information about flexibility of authorized hours in order to meet recipient needs;

7. non-covered services under PCS;

8. the requirement that each approved service plan must also be reviewed with the PCA; and

9. the procedures and forms used to verify PCA provision of services.

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

1. Authorized service hours;

2. PCA's schedule;

3. PCA's assigned tasks and pertinent care provided by informal supports; and

4. The recipient's back-up plan.

15. PCS Not Permitted

The Provider is responsible to ensure that all PCAs work within their scope of service and conduct themselves in a professional manner at all times. 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 Services - PCS services must never be confused with services of a higher level that must be performed by persons with professional training and credentials. Services that are never allowable by employees of a PCS provider include, but are not limited to, the following:

1. Insertion and sterile irrigation of catheters;

2. Irrigation of any body cavity. This includes both sterile and non sterile procedures such as ear irrigation, vaginal douches, and enemas;

3. Application of dressings involving prescription medications and aseptic techniques, including treatment of moderate or severe skin problems;

4. Administration of injections of fluids into veins, muscles, or skin;

5. Administration of medication, including, but not limited to, the insertion of rectal suppositories, the application of prescribed skin lotions, or the

instillation of prescribed eye drops (as opposed to assisting with self-administered medication);

6. Physical assessments;

7. Monitoring vital signs;

8. Specialized feeding techniques;

9. Rectal digital stimulation;

10. Massage;

11. Specialized range of motion (ROM);

12. Toenail cutting;

13. Medical case management, such as accompanying a recipient to a physician's office for the purpose of providing or receiving medical information; and

14. Any task identified within the Nurse Practice Act as requiring skilled nursing, including Certified Nursing Assistant (CNA) services.

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 services 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.

16. Supervision

a. The Provider must have qualified supervisory staff who exercise oversight of PCAs in the delivery of PCSs to assure quality care is provided.

To act as a supervisor in this program, each supervisor must have documented training or experience as a supervisor. The provider must maintain documentation of supervisory training, which must include but is not limited to certification in management/supervisory appointment, classes in supervision and interpersonal skills, including:

1. basic principles of supervision;

2. interpersonal skills for dealing with recipients and families; and

3. program policies and procedures as related to Medicaid.

b. The supervisor must review and document with the PCA the recipient's approved service plan each time an approved service plan is implemented. The supervisor must clarify with the PCA the following:

1. The needs of the recipient and tasks to be provided;

2. Any recipient specific procedures including those which may require on-site orientation;

3. Essential observation of the recipient's health; and

4. Situations in which the PCA should notify the supervisor.

Documentation of the PCA’s orientation to the approved service plan must be maintained in the recipient's record.

The 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, performed and documented in the approved service plan.

17. PCA Employment Standards – Minimum Qualifications

To be employed as a PCA for a Provider, an individual must be:

a. At least 18 years old.

b. Experienced in provision of care to people with disabilities is preferred.

c. Able to read and write or to follow written or oral instructions of the recipient or PCR.

d. In possession of the skills to perform PCS tasks as described on the approved service plan.

1. Able to be tolerant of varied life styles;

2. Able to identify emergency situations and respond accordingly;

3. Able to communicate effectively;

4. Able to document services provided;

5. Able to maintain confidentiality; and

6. Able to demonstrate a professional attitude toward work assignments and PCS needs of the recipient.

18. Training

Each PCA providing PCS is required to participate in and successfully complete an approved training program. The training program shall include basic training, periodic and continuing in-service training, and on-the-job instruction and supervision.

Each PCA must be evaluated and be determined competent prior to providing PCS to a recipient. PCAs must have successfully completed the required 16 hours of basic training or must have met the requirements for Training Waiver, discussed in this Section. The 16 hours of training must cover the mandatory subjects described in this Section. Documentation of competency to meet this requirement must be maintained for a minimum of six years. Documentation must be made available to DHCFP immediately upon request.

a. Basic Training - Basic training shall be facilitated by a supervisor and involve appropriate staff and 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.

The DHCFP expects that basic training should be interactive and not solely based on self-study guides or videotapes. This training should ensure that a PCA will be able to interact appropriately with elderly and/or disabled recipients.

An integral part of basic training shall include an evaluation of each PCA's competency in the required content. Criteria and methods for determining successful completion of basic training shall be established to determine whether each individual can perform required tasks competently and establish good working relationships with others. Methods of evaluating competency may include: written performance and oral testing; instructor observations of overall performance, attitudes, hands-on demonstrations, and work habits, or any combination of these or other methods.

Attendance records and evaluation materials for determining each individual's successful completion of basic training shall be maintained. PCAs must be given a certificate of completion for their personnel records by the training agency. The certificate must include the date of the training, the number of hours completed for each individual class, the training topic, and trainer signature.

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

1. Orientation to the provider, the approved service plan, community and Medicaid services;

2. Body mechanics and transfer techniques;

3. Bathing, basic grooming, and mobility techniques, including simple non-prescribed ROM;

4. PCSs, including PCS permitted and non permitted services (refer to Section 3503.1A);

5. Care of the home and personal belongings;

6. Infection control, including information on common communicable diseases, blood borne pathogens, infection control procedures, universal precautions and applicable OSHA requirements;

7. 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;

8. Food, nutrition, and meal preparation, including information on a well balanced diet, special dietary needs, and the proper handling and storage of food;

9. 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;

10. 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;

11. Health oriented record keeping, including written documentation of services provided and time verification records;

12. Recipient's rights, including confidentiality pursuant to state and federal regulations and consumer rights;

13. 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;

14. 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;

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

16. Cardiopulmonary resuscitation (CPR) certification, which may be obtained outside the agency. Online CPR training is insufficient to meet the requirements of this Section. PCA’s must physically attend and successfully pass CPR certification training with includes demonstration of competencies in administering CPR. Documentation of current CPR certification must be maintained in each PCA’s file by the provider; and

17. Elder abuse training to include recognizing elder abuse, sexual abuse, responding to reports of alleged abuse and instructions concerning the federal, state and local laws relating to elder abuse. Applicable laws regarding elder abuse as identified in NRS 200.5091 to NRS 200.50995 must be included. Programs may be offered by private vendors, website locations or other agencies to meet the criteria specified in the legislative language.

b. In-Service Training - The Provider shall annually provide and document a minimum of eight hours of in- service training for each PCA, no more than two hours of which can be allocated to mandated periodic CPR certification. The purpose of this annual training is to facilitate the development of specialized skills or knowledge not included in the basic training and /or to review or expand skills or knowledge included in the basic training. Consideration must be given to topics suggested by recipients.

c. On-The-Job Training - On-the-job training shall be provided by the supervisor, as needed, to instruct the PCA in a specific skill or techniques or to assist the PCA in resolving problems in individual case situations. The supervisor shall be responsible for evaluating and documenting in case notes each PCA's ability to function competently and safely and for providing or arranging for necessary on-the-job training.

d. Staff-To-Staff Training - In cases where an experienced PCA (or a family member) has extensive knowledge of a recipient's routine, he/she may assist in the direct training of another PCA. However, the supervisor is still responsible for ensuring the PCA's ability to function competently and safely in the home. The provider must document that training was delivered as required and that the PCA passed the competency test. Such records must be available upon request of the Division or its designated representative.

e. Waiver of Training Requirement - The requirement for completion of a basic training program may be waived if the individual providing PCS can provide written verification of competency based training completed within the immediately preceding 24 month period in the required areas of content included in the basic training. Criteria for evaluating competency of prior training shall include procedures and instruments for evaluating each individual's competency. Content of evaluation instruments shall be compatible with required basic training program content and shall assess appropriate skills and understanding of individuals providing PCS. Criteria shall also include documentation as to levels of competency that must be achieved by the PCAs prior to placement in a recipient's home.

In addition, the PCA must meet at least one of the following minimum requirements to be eligible for issuance of a training waiver:

1. Documented successful completion of a CNA program, or licensure as a Licensed Practical Nurse (LPN) or Registered Nurse (RN). Certification and/or licensure must be current; or

2. Documented one-year of experience as a trained PCA in a community-based agency within the immediately preceding 12 month period.

Documentation to support the waiver of training requirements must be kept in the PCA's personnel record. Waiver of basic training does not waive the annual in-service requirement.

f. Application of Training Requirement - PCAs who receive 16 hours of basic training are exempt from the in-service requirement of eight additional hours until their second year of service. Each subsequent year of employment requires eight (8) hours of in-service training.

PCAs who have a waiver of the basic training requirement are required to complete eight (8) hours of in-service training within their first year of employment and annually thereafter.

19. Complaint Procedure

The Provider must respond to all complaints in a reasonable and prompt manner. The Provider must maintain records that identify the complaint, the date received and the response and outcome of the incident.
The Provider must investigate and respond in writing to all written complaints within 10 calendar days of receipt.

The Provider will provide the recipient and the DHCFP written notification of the complaint and its outcome. As appropriate, written notification must also be provided to the waiver case manager at the local Aging and Disability Services Division (ADSD) or waiver case manager at the appropriate DHCFP District Office.

20. Serious Occurrences

The Provider must provide the local DHCFP District Office Care Coordination Unit with written notification of serious occurrences involving the recipient, the PCA, or affecting the Provider's ability to deliver services. The DHCFP District Office Care Coordination Unit must be notified of serious occurrences by fax within 24 hours of discovery. For waiver recipients, notification shall be made to both the DHCFP Care Coordination Unit

and the appropriate waiver case manager. A summary report of serious occurrences must be submitted in January and July of each year to the DHCFP Central Office PCS Program Specialist.

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

a. Suspected physical or verbal abuse;

b. Unplanned hospitalization;

c. Neglect of the recipient;

d. Exploitation;

e. Sexual harassment or sexual abuse;

f. Injuries 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 during the provision of PCS; or

j. Loss of contact with the recipient for three consecutive scheduled days.

21. 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 24 hours after there is reason to suspect a 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 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. For adults aged 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 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. have one or more physical or mental limitations that restrict the ability of the person to perform the normal ADLs contact local law enforcement agencies.

22. Termination of Services

a. The Provider may terminate services for any of the following reasons:

1. The recipient or other person in the household subjects the PCA to physical or verbal abuse, sexual harassment, and/or exposure to the use of illegal substances, illegal situations, or threats of physical harm;

2. The recipient is ineligible for Medicaid or NCU services;

3. The recipient requests termination of services;

4. The place of service is considered unsafe for the provision of PCS;

5. The recipient or PCR refuses services offered in accordance with the approved service plan;

6. The recipient or PCR is non-cooperative in the establishment or delivery of services, including the refusal to sign required forms;

7. The recipient no longer meets the PCS eligibility criteria;

8. The provider is no longer able to provide services as authorized (i.e., no qualified staff);

9. The recipient requires a higher level of services than those provided within the scope of a PCA; or

10. The recipient refuses services of a PCA based solely or partly on the basis of race, color, national origin, gender, religion, age, disability (including

AIDS and AIDS related conditions), political beliefs or sexual orientation of the PCA. A Provider's inability to provide services for a specific recipient does not constitute termination or denial from Nevada Medicaid's PCS. The recipient may choose another provider.

b. Immediate Termination - The Provider may terminate PCS immediately for reasons one through four listed in Section 3503.22(a) above.

c. Advance Notice Termination - The Provider must provide at least five calendar days advance written notice to recipients when PCS are terminated for reasons five through ten listed in 3503.22(a) above. In all cases, the Provider is responsible for making reasonable attempts to ensure continuity and appropriateness of care through referrals to other providers when appropriate.

d. Notification Requirements - The Provider must notify the recipient and all other appropriate individuals and agencies when services are to be terminated. The DHCFP District Office Care Coordination Unit should be notified by telephone within one working day. The Provider must submit written documentation within five working days.

The Provider will send a written notice advising the DHCFP District Office Care Coordination Unit or the waiver case manager of the effective date of the action of the termination of service, the basis for the action, and intervention/resolution(s) attempted prior to terminating services.

The provider is not required to send a written notice if the recipient has chosen to terminate services.

23. Records

a. 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 record retention policy, which is currently six years from the date of payment for the specified service.

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. A daily record form signed or initialed by the PCA and the recipient, attesting to the services provided and the time spent providing the service. (See daily record definition in the MSM Addendum regarding signature or initials requirements.)

24. HIPAA, Privacy, and Confidentiality

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

25. Discontinuation of Provider Agreement

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

1. provide all current recipients with written notice at least thirty (30) calendar days in advance of service discontinuation;

2. provide the DHCFP with a copy of the written notice in advance of intent to discontinue services, at least thirty (30) calendar days in advance of service discontinuation;

3. include a list of affected recipients with the notice of intent to discontinue services; and

4. continue to provide services through the notice period or until all recipients are receiving services through another Provider, whichever occurs sooner.

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

1. within five (5) calendar days of receipt of the DHCFP notification to terminate the contractual relationship, send written notification to current recipients advising the recipient will need to transfer services to a Medicaid contracted PCS provider. A current list of Medicaid contracted 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 (1) year.

3503.1C RECIPIENT RESPONSIBILITIES

1. The recipient must be able to make choices about ADLs, understand the impact of these choices, and assume responsibility for the choices. If this is not possible, the recipient must have a PCR willing to assist the recipient in making choices related to the delivery of PCS.

If the recipient utilizes a PCR, the recipient and the PCR must understand that the provision of services is based upon mutual responsibilities between the PCR and the PCS Provider.

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 LRI(s) or personal representatives;

d. treat all staff appropriately;

e. verify services were provided by, whenever possible, 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;

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; and

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

2. Recipient Rights

Every Medicaid and NCU recipient, or their PCR, who is receiving PCS, is entitled to receive a Recipient Rights statement from DHCFP, their designee or the PCS provider. The recipient should review and sign the Recipient's Rights statement.

The recipient has the right to:

a. receive considerate and respectful care that recognizes the inherent worth and dignity of each individual;

b. participate in the development of the service plan and receive an explanation of services proposed;

c. receive a copy of the approved service plan;

d. receive the telephone number of the local DHCFP District Office, which may be contacted with questions, information, or complaints;

e. receive assurance that privacy and confidentiality about one's health, social, domestic and financial circumstances will be maintained pursuant to applicable statutes and regulations;

f. know that all communications and records will be treated confidentially;

g. 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;

h. receive information upon request regarding DHCFP's policies and procedures, including information on charges, reimbursements, service plan determinations, and opportunity for fair hearing;

i. request a change of Provider;

j. request a change from Provider Agency services to a different service delivery model;

k. have access, upon request, to his or her Medicaid recipient files;

l. request a Fair Hearing if there is disagreement with DHCFP's action(s) to deny, terminate, reduce, or suspend services; and

m. receive in writing the name and contact telephone number of the Governor's Health Assistance Bureau for Hospital Patients. (Toll free telephone number: (888) 333-1597).

3503.1D CONFLICT OF INTEREST STANDARDS

The DHCFP assures the independence of contracted providers performing FAs. Physical and occupational therapists who perform FAs 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; or

4. related by blood or marriage to the Provider who provides PCS to the individual.

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

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

3503.1E AUTHORIZATION PROCESS

1. Prior Authorization

For all initial and reassessment requests for PCS, a physical or occupational therapist will complete the FA for all Medicaid recipients. The DHCFP's QIO-like vendor will complete the service plan and authorize services for all Medicaid recipients. The approved prior

authorization document includes the dates of service, hours and time per day, the number of days per week, and the total authorized units per billing cycle.

Providers must bill only for the dates when services were actually provided, in accordance with the appropriate billing manual. For instance, if services were provided on Monday March 16, Wednesday March 18 and Friday March 20, providers should only bill for those specific dates and not for the entire week's date range.

A PA number will be assigned by the QIO-like vendor, and must be included on all claims submitted for reimbursement. See Section 3503.1D.5 reimbursement section later in this Chapter.

All other authorization requests must be submitted to the QIO-like vendor using the following procedure:

a. Initial Requests - Requests for FAs to initiate PCS are submitted to the QIO-like vendor and can be made by the recipient, a LRI, PCR or individuals covered under the confidentiality requirements of HIPAA. Initial requests may not be made by providers.

The QIO-like vendor validates that the recipient meets PCS criteria, and if so, will provide the recipient with a list of enrolled and trained physical or occupational therapists to select from for completion of the FA. If the recipient has no preference, then the QIO-like vendor will assign a physical/occupational therapist to complete the FA.

The recipient is responsible for scheduling and keeping the appointment with the physical or occupational therapist for completion of the FA.

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

After completion of the FA, it will be forwarded to the QIO-like vendor, who will continue to the process identified in 3503.1E.1.

b. At Risk Recipient Requests

Upon receipt of a request for an initial FA, the QIO-like vendor will first complete a risk assessment over the phone, to identify those recipients for whom PCS are urgent to avoid institutionalization, or for whom the service need is the result of an acute medical condition or loss of a primary caregiver or LRI. The intent of the

telephonic risk assessment is to determine if a recipient is at risk of losing or being unable to return to a community setting because of the need for PCS.

When a recipient determined "at risk", the QIO-like vendor will provide a temporary service authorization and make an immediate referral to the DHCFP District Office's Care Coordination Unit. If needed, the Care Coordination Unit will assist the recipient in accessing a physical or occupational therapist and an available Provider Agency.

The QIO-like vendor will provide the recipient with a list of enrolled and trained physical or occupational therapists to select from for completion of the FA. If the recipient has no preference, then the QIO-like vendor will assign a physical/occupational therapist to complete the FA.

The recipient is responsible for scheduling and keeping the appointment with the physical or occupational therapist for completion of the FA.

The selected Provider Agency is notified when a recipient is at risk and agrees, by accepting the case, to initiate needed services within twenty-four (24) hours of case acceptance. The approved service plan and authorization document are faxed to the provider upon acceptance. All other policies in Section 3503.1 apply.

c. Reassessment Requests

Authorizations for PCS are issued by the QIO-like vendor for periods not to exceed one year. Reassessment requests for ongoing services must be submitted to the QIO-like vendor at least 30 calendar days prior to the expiration date of the prior authorization. The request must be submitted on the QIO-like vendor request form specific to PCS. The form includes all required recipient and provider information as well as the units requested and the dates of service for the service interval requested.

d. Significant Change Requests

Requests for reassessment due to significant change in the recipient's condition or circumstances must be submitted to the QIO-like vendor as soon as the significant change is known. A request for reassessment due to significant change in the recipient's condition or circumstances must be accompanied by documentation from the recipient's physician or health care provider.

Significant change in condition may be demonstrated by, for example, a recent hospitalization (within past 14 days), a physician's visit (within past seven days)

resulting in an exacerbation of previous disabling condition, or a new diagnosis not expected to resolve within 30 days.

Significant change in circumstances may include such circumstances as absence, illness, or death of the primary caregiver or LRI.

Significant change in condition or circumstances expects imminent hospitalization or other institutional placement if PCS are not reassessed to meet the recipient's change in service needs.

2. Flexibility of Services

Flexibility of service delivery which does not alter medical necessity may occur within a single week period without an additional authorization or change in the service plan. This flexibility must demonstrate and document the needs of the recipient, as documented in the approved service plan, and must not take place solely for the convenience of the Provider or the PCA. Documentation of flexibility within a single week must be reflected in the recipient's file.

3. Changes to the Service Plan

When the recipient has an unexpected change in condition or circumstance which requires short-term (less than four weeks) modification of the current service plan and authorization, a new FA is not required. Such a modification is considered in, but is not limited to, the following circumstances:

a. Additional PCS are required for a short time as the result of an acute medical episode or during a post-hospitalization period.

b. A reduction in PCS is requested as a result of improvement in the functional abilities of the recipient or the availability of a LRI to assist with providing PCS.

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

1. Documentation must be maintained in the recipient's record of the circumstances that required the short term modification(s) of the approved service plan;

2. Documentation of the short-term modifications of the approved service plan must be completed and sent to the QIO-like vendor and the appropriate home and community-based waiver case manager. The

recipient's signature is not required; however, see item 3 in this section. Documentation must include the recipient's name, Medicaid number, service level, and the dates during which the modified service plan will be in effect;

3. Documentation must be maintained in the recipient's record that the recipient participated in the development of the modified service plan, including date and method of contact with the recipient;

4. The recipient must be sent a written copy of the modified service plan immediately upon completion; and

5. Upon expiration of the modified service plan, the recipient's original approved service plan is automatically reinstated unless a new FA and service plan are completed due to a significant change in the recipient's condition or circumstance.

4. Single-Service Authorization Request

The recipient's Provider Agency may submit a single-service authorization request, when the recipient requires an extra visit for an unanticipated need(s), such as bowel or bladder incontinence. The Provider Agency must document the medical necessity of the services requested and be the designated provider for the current authorization period. A new FA is not required in these single-service situations.

5. Mileage Authorization Request

Mileage for travel to and from a recipient's home or for shopping is not reimbursable to PCS providers, except in hardship situations in remote or rural areas of the state, where failure to reimburse mileage expenses would severely limit available paid caregivers. Mileage must be approved in advance by the DHCFP District Office care coordinator on a case-by-case basis. The care coordinator will notify the QIO-like vendor of the actual approved mileage. The QIO-like vendor will issue all authorization numbers.

6. Reimbursement

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

a. Time spent completing administrative functions such as supervisory visits, scheduling, chart audits, surveys, review of service delivery records and personnel consultant;

b. The cost of criminal background checks and TB testing;

c. Travel time to and between recipients home;

d. The cost of basic training, in-service requirements and the CPR and First Aid requirement; and/or

e. Routine supplies customarily used during the course of visits, including but not limited to non-sterile gloves.

7. Improper Billing Practices

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

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

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

a. submitting claims for unauthorized visits;

b. submitting claims for services not provided, for example billing a visit when the recipient was not at home but the PCA was at the recipients residence;

c. submitting claims for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider’s signature, the month, day, year, and exact time in and out of the recipients home. Providers shall submit or produce requested documentation upon request of DHCFP staff;

d. submitting claims for unnecessary visits or visits that are in excess of amount, scope and duration necessary to reasonably achieve its purpose;

e. billing for the full authorized number of units when they exceed the actual amount of service units provided; or

f. submitting claims for PCS services provided by an unqualified paid PCA.

Any PCS or other provider who bills DHCFP for services rendered by a PCA who has not met all the requirements of this chapter at the time services were rendered (including requirements involving TB testing, training, CPR certification, and criminal background checks) is subject to all administrative and corrective sanction and recoupment's listed in the MSM, Chapter 3300. Any such action taken against a provider by DHCFP has no bearing on any criminal liability of the provider.

8. Overpayments

All Medicaid overpayments are subject to recovery.

3503.2 SERVICES TO CHILDREN – COVERAGE AND LIMITATIONS

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

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

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

In authorizing PCS services to Medicaid eligible children, the FA factors in the age and developmental level of the child as well as the parental ability and capability to provide the child's personal care needs.

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

Housekeeping tasks are limited directly to the provision of PCS, such as cleaning the bathtub/shower after a bath/shower has been given. Time is allocated under the bathing task and is not an additional service. When a recipient lives with a parent or other LRI, it is the responsibility of the LRI to perform specific housekeeping tasks, other than those which are incidental to the performance of Personal Care tasks. This includes, but is not limited to other housekeeping tasks, meal preparation, essential shopping, and escort services. All other policies in Section 3503.1 A through D inclusive apply.

3503.3 PCS SERVICES FOR HOME AND COMMUNITY-BASED WAIVER (HCBW) RECIPIENTS

Recipients who are Medicaid eligible under a HCBW are eligible for all State Plan services (including PCS) within individual State Plan service policies.

All policies identified in Section 3503.1 A through D inclusive apply. HCBW Case Managers authorize waiver services.

3503.4 PCS FOR RECIPIENTS ENROLLED IN HOSPICE

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

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

3503.5 OUT-OF-STATE (OOS) SERVICES

PCS are allowed OOS for Nevada Medicaid recipients absent from Nevada. OOS PCS are subject to the same limitations and reimbursement as in-state PCS. The recipient or the PCR is responsible for locating PCS OOS. The QIO-like vendor should be contacted for information on OOS PCS agencies' enrollment as a Nevada Medicaid Provider.

3503.5A COVERAGE AND LIMITATIONS

In addition to the policies described in Section 3503.1A, of this Chapter, the following policies apply for services OOS.

1. OOS services may be authorized when:

   a. there is a medical emergency and the recipient's health would be endangered if he or she were required to return to the State of Nevada to obtain medical services;

   b. the recipient travels to another State because the DHCFP has determined the required medical service is not available in Nevada and has authorized the recipient to receive services from an OOS provider;

   c. the DHCFP determines that it is general practice for recipients in a particular locality to use medical services in another state (e.g., Nevada counties that border other State lines); or

   d. the recipient is on personal business. The DHCFP may reimburse for these services. The time authorized for services is documented in the approved service plan, regardless of the location of services.

2. The recipient who wishes his or her regular PCA to accompany him or her OOS must contact the Provider Agency to determine if this is allowable per the provider's policy. Travel time for the PCA is not reimbursable by the DHCFP. Refer to 3503.8 for information regarding Escort Services.

3503.5B OUT-OF-STATE (OOS) PROVIDER RESPONSIBILITY

1. The OOS PCS provider must contact the DHCFP QIO-Like vendor to become a Nevada Medicaid provider.

2. OOS PCS providers must comply with all policies specified in Section 3503.1B.

   a. Certain PCS provider enrollment requirements may be waived at the discretion of the DHCFP for OOS providers on a case-by-case basis. Consideration will be given to factors including:

      1. location;

      2. length of time recipient will stay in the state; and

      3. local Medicaid or licensure requirements.

3503.5C RECIPIENT RESPONSIBILITY – SERVICES OUT-OF-STATE (OOS)

The recipient or their PCR should contact the DHCFP QIO-Like vendor to assist with OOS PCS provider enrollment.

All other policies specified in Section 3503.1 of this Chapter apply.

3503.6 PREGNANCY

Pregnant women are not considered in need of PCS based solely upon their pregnancy. However, there are instances where complications arise and women are ordered to bed rest. When it poses imminent danger to the mother or unborn child to perform ADLs, services may be authorized. Such cases should be referred to the DHCFP District Office Care Coordination Unit.

If the condition is alleviated as documented by the obstetrician or delivery is completed, the PCS provider must notify Nevada Medicaid (or designee) immediately to terminate services.

Services provided to care for the mother's young children while she remains on bed rest are not provided.

All other policies found in Section 3503.1 of this Chapter apply.

3503.7 SUPPORTED LIVING ARRANGEMENT (SLA)

Recipients in SLA settings may receive State Plan PCS if services are determined to be medically necessary and are non-duplicative of services provided by the SLA. In order to be determined medically necessary and appropriate, the recipient who is residing in a SLA, should be referred to the local DHCFP Care Coordination Unit. The Care Coordinator will contact the Division of Mental Health and Developmental Services (MHDS) about the specific SLA resident to determine the functions the SLA has contracted to provide to assist the recipient with ADLs and IADLs.

The Care Coordinator will then make a referral to a physical or occupational therapist to complete a FA and the QIO-like vendor will complete the service plan. The FA and service plan will be completed factoring in the responsibility of the SLA. PCS will be authorized following protocol outlined in this Chapter.

3503.8 ESCORT SERVICES

Escort services may be authorized in certain situations for recipients who require a PCA to perform an approved PCS en route to or while obtaining Medicaid reimbursable services.

3503.8A COVERAGE AND LIMITATIONS

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

1. The needed PCS is currently an authorized task on the approved service plan and will be provided during the course of the visit.

2. The PCS required are an integral part of the visit. Covered personal care tasks would include undressing/dressing, toileting, transferring/positioning, ambulation and eating. For example, transferring a recipient on and off an examination table is an integral part of a physician visit.

3. A LRI is unavailable to provide the personal care task during the appointment.

4. Staff at the site of the visit, (surgery center, physician's office, clinic setting, outpatient therapy site or other Medicaid reimbursable setting) are unable to assist with the needed personal care task.

3503.8B PROVIDER RESPONSIBILITY

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

2. The provider must include all the above information when submitting the prior authorization request, including the date of service and the amount of time requested.

3. The provider must comply with all other policies in Section 3503.1B.

3503.8C AUTHORIZATION PROCESS

1. The provider must contact QIO-like vendor, the ADSD or Waiver for Persons with Physical Disabilities DHCFP case manager, as appropriate, for prior authorization for escort services.

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

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

3503.9 TRANSPORTATION

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

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

3503.10 QUALITY ASSURANCE

The DHCFP conducts Provider reviews, both announced and unannounced, to examine provider's records for compliance with PCS program requirements, procedures and policies. All providers and their staff must fully cooperate with the DHCFP staff, or their designee, before, during and after such reviews.

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

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

3504 HEARINGS

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