Medicaid Services Manual
Transmittal Letter

December 26, 2023

To: Custodians of Medicaid Services Manual

From: Casey Angres
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 3500 – Personal Care Services Program

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 3500 – Personal Care Services Program are being proposed to remove Section 3503.1G Electronic Visit Verification (EVV) system, which will be added to Addendum B, specifically created to outline EVV system, provider, and recipient requirements.

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

Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers delivering personal care services requiring the use of an EVV system. These provider types (PT) include Personal Care Services (PT 30).

Financial Impact on Local Government: None.

These changes are effective January 1, 2024.

Material Transmitted	Material Superseded
MTL OL MSM Ch 3500 – Personal Care Services Program	MTL 21/19 MSM Ch 3500 – Personal Care Services Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3503.1G	**Electronic Visit Verification (EVV)**	EVV policy section has been removed from MSM Chapter 3500 to be added to the newly created Addendum B.
3503.1H(3)	**Provider Responsibilities**	New language added referencing Addendum B for EVV system requirements.

1. Upon receipt of an initial service plan from the QIO-like vendor, the provider must meet with the recipient in person to determine how the total weekly authorized hours will be provided to meet the individual's needs.

2. Written documentation of the contact with the recipient regarding provision of services must be maintained in the recipient's file.

3. Any change to the approved service plan must be discussed between the provider and the recipient. This may be done either in person or via the telephone in order to determine how the hours and tasks will be provided.

4. Changes may be requested on a daily and/or weekly basis when necessary to meet a change in circumstance or condition.

5. The PCS provider must follow their established policies and procedures in order to timely meet recipient requests for changes in service delivery.

6. Written documentation of the contact with the recipient regarding any change to the approved service plan must be maintained in the recipient's file.

~~3503.1G ELECTRONIC VISIT VERIFICATION (EVV)~~

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

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

~~Provider Agencies must ensure each personal care attendant (PCA) has a unique identifier (National Provider Identification – NPI) associated with their worker profile in the EVV system.~~

~~1. STATE OPTION~~

~~a. The EVV system electronically captures:~~

~~1. The type of service performed, based on procedure code;~~

~~2. The individual receiving the service;~~

~~3. The date of the service;~~

~~4. The location where service is provided;~~

~~5. The individual providing the service;~~

~~6. The time the service begins and ends.~~

~~b. The EVV system must utilize one or more of the following:~~

~~1. The agency/PCA's smartphone;~~
~~2. The agency/PCA's tablet;~~

~~3. The recipient's landline telephone;~~

~~4. The recipient's cellular phone (for Interactive Voice Response (IVR) purposes only);~~

~~5. Another GPS-based device as approved by the DHCFP.~~

~~2. DATA AGGREGATOR OPTION~~

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

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

~~2. At a minimum, data uploads must be completed monthly into data aggregator.~~

3503.1~~GH~~ CONFLICT OF INTEREST STANDARDS

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

1. Related by blood or marriage to the individual or to any paid caregiver of the individual;

2. Financially responsible for the individual;

3. Empowered to make financial or health-related decisions on behalf of the individual;

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

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

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

3503.~~1~~1H PROVIDER RESPONSIBILITIES

PCS providers shall furnish 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.

Additionally, all PCS providers have the following responsibilities:

1. Licensure

   In order to enroll as a Nevada Medicaid PCS Provider, a provider must be licensed by the Division of Public and Behavioral Health (DPBH) as an Agency to Provide Personal Care Services in the Home (personal care agency).

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

2. Provider Enrollment

   To become a Nevada Medicaid PCS provider, the provider must enroll with the QIO-like vendor as a Personal Care Services – Provider Agency (PT 30).

3. Electronic Visit Verification (EVV)

   Utilize an EVV system that meets the requirements of the 21st Century Cures Act, to electronically document the personal care services provided to Medicaid recipients served by a Medicaid provider. Refer to Addendum B for more information about EVV system requirements.

4. 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 working days of an accepted referral and within 24 hours of an accepted referral if the recipient is identified as "at risk" by the DHCFP or its designee.

   PCS providers must meet the conditions of participation as stated in the MSM Chapter 100.

The Provider must comply with all local, state and federal regulations, and applicable statutes, including, but not limited to, Nevada Revised Statutes Chapter 449, Nevada Administrative Code Chapter 449, the Internal Revenue Service (IRS), Federal Insurance Contributions Act (FICA), Occupational Safety and Health Act (OSHA), the Health Insurance Portability and Accountability Act (HIPAA) and the 21st Century Cures Act.

5. 24-Hour Accessibility

The Provider shall maintain an available telephone line 24 hours per day, seven days per week for recipient contact.

6. Backup Mechanism.

The Provider shall have a backup mechanism to provide a recipient with his or her authorized service hours 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 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 prior to providing services. All initial and ongoing services must be prior authorized by the DHCFP's QIO-like vendor. Services which have not been prior authorized will not be reimbursed.

9. Provider Liability

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

10. Direct Marketing

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

in door-to-door, telephone, direct mail, email or any other type of cold-call marketing activities.

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

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

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

11. Medicaid and NCU Eligibility

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

12. 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;

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

10. EVV requirements and recipient participation.

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

1. Authorized weekly service hours;

2. PCA's schedule;

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

4. The recipient's back-up plan.

13. 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 Care Services requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or certified by the State, are not permitted to be provided by employees of a PCS Agency. PCS services must never be confused with services of a higher level that must be performed by persons with professional training and credentials.

b. Increasing and/or decreasing time authorized on the approved service plan;

c. Accepting or carrying keys to the recipient's home;

d. Purchasing alcoholic beverages for use by the recipient or others in the home unless prescribed by the recipient's physician;

e. Making personal long-distance telephone calls from the recipient's home;

f. Performing tasks not identified on the approved service plan;

g. Providing services that maintain an entire household;

h. Loaning, borrowing or accepting gifts of money or personal items from the recipient;

i. Accepting or retaining money or gratuities for any reason other than that needed for the purchase of groceries or medications for the recipient;

j. Care of pets except in the case where the animal is a certified service animal.

14. Supervision

A supervisor (or other designated agency representative) must review with the PCA the recipient's approved service plan. This must be done each time a new service plan is approved. Documentation of the approved service plan's review must be maintained in the recipient's record.

The supervisor (or other designated agency representative) must clarify with the PCA the following:

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

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

c. Essential observation of the recipient's health;

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

e. EVV requirements and expectations, including the documentation of all personal care services in an approved EVV system.

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 which are provided according to the approved service plan and are documented on the service delivery records.

15. Complaint Procedure

The Provider must investigate and respond in writing to all complaints in a reasonable and prompt manner. The Provider must maintain records that identify the complaint, the date received, the outcome of the investigation and the response(s) to the complaint.

16. Serious Occurrences

The Provider must report all serious occurrences involving the recipient, the PCA, or affecting the provider's ability to deliver services. The Nevada DHCFP Serious Occurrence Report must be completed within 24 hours of discovery and submitted to the local DHCFP

District Office. If the recipient is on a Home and Community Based Waiver (HCBW), the notification shall be made directly to the HCBW case manager's Aging and Disability Services (ADSD) office.

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

a. Suspected physical or verbal abuse;

b. Unplanned hospitalization or ER visit;

c. Neglect of the recipient;

d. Exploitation;

e. Sexual harassment or sexual abuse;

f. Injuries or falls requiring medical intervention;

g. An unsafe working environment;

h. Any event which is reported to Child or Elder Protective Services or law enforcement agencies;

i. Death of the recipient;

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

k. Medication errors;

l. Theft;

m. Medical Emergency;

n. Suicide Threats or Attempts.

17. Notification of Suspected Abuse or Neglect

State law requires that persons employed in certain capacities make a report to a child protective service agency, an aging and disability services agency or law enforcement agency immediately, but in no event later than 24 hours after there is reasonable cause to believe a child, adult or older person has been abused neglected, exploited, isolated or abandoned.
For recipients under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. For adults age 60 and over, the ADSD accepts reports of suspected abuse, neglect or self-

neglect, exploitation or isolation. For all other individuals (other age groups) contact local law enforcement.

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

18. 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;

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

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. Notification Requirements – The Provider must notify the recipient and all other appropriate individuals and agencies of the date when services are to be terminated. The DHCFP District Office Care Coordination Unit should be notified by telephone one business day prior to the date services will be terminated. If the recipient is on an HCBW the notification should be made directly to the HCBW case manager's ADSD office.

The Provider must submit written notice, within five working days, 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.

19. 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. The PCA's supervisor (or other designated agency representative) must review and approve all service delivery records completed by the PCA. The provider will only be paid for the hours and tasks authorized on the approved service plan, which are clearly documented as being provided on the service delivery records.

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

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

21. Discontinuation of Provider Agreement

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

1. Provide all current Medicaid recipients with written notice at least 30 calendar days in advance of service discontinuation advising the recipient will need to transfer to a Medicaid contracted PCS provider. A current list of Medicaid contracted PCS Providers must be obtained from the QIO-like vendor and included with the notification;

2. Provide the DHCFP with a copy of the written notice of intent to discontinue services, including a list of the affected recipients, at least 30 calendar days in advance of service discontinuation;

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

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

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

2. Provide reasonable assistance to recipients in transferring services to another provider.

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

3503.~~1J~~1I RECIPIENT RESPONSIBILITIES AND RIGHTS

1. Recipient Responsibilities

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 PCR;