Medicaid Services Manual
Transmittal Letter

October 29, 2024

To: Custodians of Medicaid Services Manual

From: Casey Angres *Casey Angres* Casey Angres (Dec 9, 2024 11:38 PST)
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 2600 – Intermediary Service Organization - (ISO)

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 2600 – Intermediary Service Organization are being proposed to add language to reflect the Senate Bill (SB)511 mandating providers to adhere to the wage requirements established by federal or state law or applicable Medicaid requirements for direct care workers. Additionally, a process to ensure providers comply with the wage requirements was added indicating the DHCFP Audit Unit will be conducting audits.

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

Entities Financially Affected: None.

Financial Impact on Local Government: Unknown at this time.

These changes are effective November 1, 2024.

Material Transmitted	Material Superseded
MTL 22/24 Chapter 2600 - Intermediary Service Organization – (ISO)	MTL 20/19 Chapter 2600 - Intermediary Service Organization – (ISO)

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2603.8(V)	**Provider Responsibilities**	Language added to align with SB511 wage requirements

DIVISION OF HEALTH CARE FINANCING AND POLICY

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2600 INTRODUCTION

INTERMEDIARY SERVICE ORGANIZATION - (ISO)

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

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

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

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

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

All providers must be contracted with the Division of Health Care Financing and Policy (DHCFP) in accordance with Chapter 100 and meet certain qualifications and criteria as discussed later in this chapter.

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

2601 AUTHORITY

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

Regulatory oversight:

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

2602 DEFINITIONS

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

2603 POLICY

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

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

2603.1 SELF-DIRECTED PERSONAL CARE SERVICES (PCS)

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

Services are available to recipients in need of PCS, including persons with cognitive impairments, who have the ability and desire to manage their own care. When the recipient does not have the ability to manage their own care, a PCR may do so on their behalf.

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

2603.1A ELIGIBILITY CRITERIA

1. The recipient must have ongoing Medicaid or Nevada Check Up (NCU) eligibility for services;

2. The recipient is not in a hospital, Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an institution for the mentally ill or a licensed residential facility for groups;

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

4. The recipient must be able to make choices about ADLs, understand the impact of these

choices and assume responsibility for them or have a PCR who is willing to assist the recipient in making choices and assumes responsibility for those choices;

5. The recipient or PCR must be cooperative in establishing the need for the provision of services and comply with the approved service plan;

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

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

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

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

1. The DHCFP District Office or local ADSD Office staff provides information to the recipient or the PCR about the self-directed services available. If the recipient is interested in self-direction, a list of enrolled Medicaid ISO providers is provided to the recipient to choose and initiate contact with the ISO of his or her choice.

2. If the recipient elects to self-direct his or her own PCS, the ISO will provide, and the recipient will sign, the ISO Self-Directed Personal Care Services Unskilled Only Recipient Agreement.

3. If the recipient elects a PCR to direct his or her care, the ISO will provide, and the PCR will sign, the ISO Self-Directed Personal Care Services Unskilled Only Personal Care Representative Agreement.

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

2603.1C COVERAGE AND LIMITATIONS

1. Covered Services

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

      1. Bathing/dressing/grooming.

      2. Toileting needs and routine care of an incontinent recipient.

3. Transferring and positioning non-ambulatory recipients from one stationary position to another, assisting a recipient out of bed, chair or wheelchair, including adjusting/changing recipient's position in a bed, chair or wheelchair.

4. Mobility/Ambulation, which is the process of moving between locations, including walking or helping the recipient to walk with support of a walker, cane or crutches or assisting a recipient to stand up or get to his/her wheelchair to begin ambulating.

5. Eating, including cutting up food. Specialized feeding techniques may not be used.

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

1. Meal preparation, which includes storing, preparing and serving food.

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

3. Light housekeeping, which includes changing the recipient's bed linens, dusting, or vacuuming the recipient's living area.

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

2. Service Limitations

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

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

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

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

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

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

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

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

3. Non-Covered Services

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

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

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

b. Services normally provided by an 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. Skilled care services requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or certified by the State. Services include, but are not limited to, the following:

1. Insertion and sterile irrigation of catheters;

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

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

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

5. Administration of medication, including, but not limited to, the insertion of rectal suppositories, the application of prescribed skin lotions, or the instillation of prescribed eye drops (as opposed to assisting with self-administered medication);

6. Physical assessments;

7. Monitoring vital signs;

8. Specialized feeding techniques;

9. Rectal digital stimulation;

10. Massage;

11. Specialized range of motion (ROM);

12. Toenail cutting;

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

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

g. Chore services.

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

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

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

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

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

m. Transportation of the recipient by the PCA.

n. Any other service not listed under Section 2603.1C.1.

2603.1D AUTHORIZATION PROCESS

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

1. Initial Authorization Requests

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

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

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

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

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

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

a. At Risk Recipient Requests

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

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

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

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

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

2. Annual Update Authorization Requests

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

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

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

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

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

3. Significant Change in Condition or Circumstance Authorization Requests

Requests for reassessment due to significant change in the recipient's condition or circumstances must be submitted to the QIO-like vendor as soon as the significant change is known. A request for reassessment due to significant change in the recipient's condition or circumstances must be submitted on the Authorization Request for PCS form (FA-24) and must be accompanied by documentation from the recipient's physician or health care

provider. Requesting a reassessment does not guarantee an increase in previously approved PCS.

a. Significant change in condition may be demonstrated by, for example, an exacerbation of a previous disabling condition resulting in a hospitalization (within past 14 days) or a physician's visit (within past seven days) or a new diagnosis not expected to resolve within eight weeks.

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

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

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

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

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

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

4. Temporary Service Authorization Requests

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

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

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

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

b. Documentation of the short-term modification(s) of the approved service plan must be completed and sent to the ISO, and if applicable the appropriate home and community-based waiver case manager. Documentation must include the recipient's name, Medicaid number, and the dates during which the modified service plan will be in effect; and

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

5. One-Time Service Authorization Request

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

6. Mileage Authorization Request

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

2603.1E FLEXIBILITY OF SERVICE DELIVERY

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

The following requirements must be met:

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

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

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

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

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

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

2603.1F CONFLICT OF INTEREST STANDARDS

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

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

2. financially responsible for the individual;

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

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

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

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

2603.2 LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

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

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

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

2603.3 PERSONAL CARE REPRESENTATIVE (PCR)

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

For the self-directed service delivery model, the PCR is responsible to hire, manage and schedule PCAs, assumes responsibility for training and manages all paperwork functions.

The PCR must:

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

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

C. give due consideration to all information including the recommendations of other interested and involved parties; embody the guiding principles of self-determination; and

D. understand that provision of services is based upon mutual responsibilities between the PCR and the ISO.

A PCR is not eligible to receive reimbursement from Medicaid for this activity. A recipient's paid PCA cannot be the recipient's PCR. The PCR must meet all criteria outlined in Section 2603.9 of this chapter. In addition, this individual must be present for the provision of care on a consistent basis, as well as sign daily records. For this reason, it is not allowable for individuals such as a paid PCA, care coordinator or case manager to assume this role.

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

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

2603.4 SERVICES TO CHILDREN

An LRI of a minor child has a duty/obligation to provide the child necessary maintenance, health/medical care, education, supervision and support. Necessary maintenance includes, but is not limited to, the provisions of ADLs and IADLs. Payment will not be made for the routine care,

supervision or services normally provided for the child without charge as a matter of course in the usual relationship among members of the nuclear family.

PCS are not a substitute for natural and informal supports provided by family, friends, or other available community resources; however, are available to supplement those support systems so the child is able to remain in the home. LRIs may not be reimbursed by Medicaid for PCS services. PCS for children with disabilities may be appropriate when there is no legally responsible, available and capable parent or LRI, as defined by the DHCFP, to provide all necessary personal care. Documentation verifying that the recipient's parent or LRI is unavailable or incapable must be provided upon request. In authorizing PCS services to Medicaid eligible children, the FASP factors in the age and developmental level of the child as well as the parent or LRI's availability and capability to provide the child's personal care needs.

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

Housekeeping tasks are limited directly to the provision of PCS, such as cleaning the bathtub/shower after a bath/shower has been given. Time is allocated under the bathing task and is not an additional service. When a recipient lives with an 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.

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

All other policies in this chapter apply.

2603.5 PCS FOR RECIPIENTS ENROLLED IN HOSPICE

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

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

The PCS provided by a PCA to a recipient because of needs unrelated to the terminal condition

may not exceed program limits and guidelines.

2603.6 RESIDENTIAL SUPPORT SERVICES/SUPPORTED LIVING ARRANGEMENT (SLA)

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

2603.7 SELF-DIRECTED (SD) SKILLED SERVICES

SD Skilled Services are skilled services provided to a recipient by an unlicensed personal care assistant. This option is offered by Nevada Medicaid under the authority of NRS 629.091, where a provider of healthcare can authorize an unlicensed personal care assistant to provide certain specific medical, nursing or home health services, subject to a number of conditions. All skilled services that are self-directed and provided by an unlicensed personal care assistant require a doctor's order and prior authorization.

2603.7A PROGRAM ELIGIBILITY CRITERIA

In addition to the requirements listed in Section 2603.1A, the following requirements must be met to be determined eligible for SD Skilled Services:

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

2. The primary physician has determined the procedures involved in providing the services are simple and the performance of such procedures by the personal care assistant does not pose a substantial risk to the person with a disability;

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

4. The PCA agrees with the provider of health care to refer the person with a disability to the primary physician in accordance with NRS 629.091;

5. Services must be provided in the presence of the LRI or PCR if the recipient is unable to direct their own care, as in the case of a minor or a cognitively impaired adult, in accordance with NRS 629.091.

2603.7B INITIATING SD SKILLED SERVICES

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

1. The local DHCFP or ADSD Office staff provides information to the recipient, the LRI or the PCR about the self-directed services available. If the recipient is interested in self-direction, a list of enrolled Medicaid ISO providers is provided to the recipient to choose and initiate contact with the ISO of his or her choice.

2. The ISO will provide the recipient with the Authorization Request for Self-Directed Skilled Services Authorization Form (FA-24C) for completion.

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

2603.7C COVERAGE AND LIMITATIONS

1. COVERED SERVICES

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

a. The service(s) are medically necessary and required to maintain or improve the recipient's health status;

b. The service(s) performed must be one that a person without a disability usually and customarily would personally perform without the assistance of a provider of health care;

c. The service(s) must be sufficient in amount, duration and scope to reasonably achieve its purpose;

d. The service(s) must have prior authorization.

2. Non-Covered Services

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

a. Services provided in a physician's office, clinic or other outpatient setting;

b. SD Skilled Services provided in the absence of an LRI or PCR for those individuals who are not able to direct their own care; or

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

3. Medical Criteria

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

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

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

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

3. Highly Complex Intervention - Intervention that by its inherent complexity combined with the frequency in the recipient's care routine can reasonably be expected to exceed one and one-half or more hours per day to perform. Highly complex interventions may include but are not limited to: tube

feedings; special swallow techniques; peritoneal dialysis; Stage III or IV wound care; or care of Stage II to Stage IV wounds in multiple locations. A physician must provide a written rationale for the time requested to perform this intervention.

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

c. Additional major procedures not listed here may be considered in determining the complexity of skilled intervention. The DHCFP's QIO-like vendor, or their designee, should be contacted with information on what the procedure is and the amount of skilled time needed to perform this procedure or task.

d. Clinical Decision Support Guide – See Section 2606. The Clinical Decision Support Guide identifies the benefit limitations for individual recipients based upon supporting documentation provided by the physician that describes the complexity of the recipient's care and the frequency of skilled interventions. Services must be appropriate, reasonable and necessary for the diagnosis and treatment of the recipient's illness or injury within the context of the recipient's unique medical condition and the standard of practice within the community.

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

4. Crisis Override

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

a. Coverage and Limitations

1. Additional services may be covered up to 20% above program limits.

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

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

2603.7D AUTHORIZATION PROCESS

Prior authorization must be obtained before services can be provided. SD Skilled Services are authorized by the DHCFP's QIO-like vendor. Services must be requested using Code T1019 plus a TF modifier to represent SD Skilled Services If the TF modifier is not requested, reimbursement for SD Skilled Services will not be approved and subsequent claims will be denied.

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

2. The QIO-like vendor reviews the request and supporting documentation utilizing criteria identified in the Clinical Decision Support Guide. The QIO-like vendor will use these criteria to review for medical necessity and utilization control procedures.

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

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

2603.8 PROVIDER RESPONSIBILITIES

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

Additionally, all ISO providers have the following responsibilities:

A. Certification and/or Licensure

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

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

B. Provider Enrollment

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

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

The provider must comply with all local, state and federal regulations and applicable statutes, including but not limited to Nevada Revised Statutes Chapters 449 and 629, the Internal Revenue Service (IRS), Federal Insurance Contributions Act (FICA), Occupational Safety and Health Act (OSHA), the Health Insurance Portability and Accountability Act (HIPAA) and the 21st Century Cures Act.

C. Employer of Record

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

D. Electronic Visit Verification (EVV)

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

E. Recipient Education

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

F. Personal Care Assistant (PCA) List

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

G. Backup List

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

H. Backup Plan

The ISO may, upon request, assist the recipient in developing a written back-up plan to address personal care service needs in the event that care is interrupted. This may include providing a current list of PCAs available to assist in providing appropriate back-up services. The ISO is responsible for documenting the back-up plan that is developed but is

not responsible for arranging or ensuring back-up care is provided, as this is the responsibility of the recipient, their LRI or PCR.

I. Medicaid and Nevada Check Up (NCU) Eligibility

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

J. Prior Authorization

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

K. Service Initiation

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

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

2. The ISO must review with the recipient, their LRI or PCR the approved service plan, weekly hours, tasks to be provided and EVV requirements and recipient participation.

3. The ISO must review with the recipient, their LRI or PCR his or her responsibility to establish the PCA's schedule and to establish his or her own back-up plan.

4. The ISO provider must review with the recipient, their LRI or PCR the differences between the Agency and the SD Service Delivery Model.

L. PCS Not Permitted

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

1. Skilled Care Services requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or certified by the State. PCS services must never be confused with services of a higher level that must be performed by persons with professional training and credentials;

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

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

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

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

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

7. Providing services that maintain an entire household;

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

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

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

M. Supervision

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

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

N. Provider Liability

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

O. Notification of Suspected Abuse or Neglect

State law requires that persons employed in certain capacities make a report to a child protective service agency, an aging and disability services agency or law enforcement agency immediately, but in no event later than 24 hours after there is reasonable cause to believe that a child, adult or older person has been abused, neglected, exploited, isolated or abandoned.

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

individuals (other age groups) contact local law enforcement.

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

P. Serious Occurrences

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

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

1. Suspected physical or verbal abuse;

2. Unplanned hospitalization or ER visit;

3. Neglect of the recipient;

4. Exploitation;

e. Sexual harassment or sexual abuse;

f. Injuries or falls requiring medical intervention;

g. An unsafe working environment;

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

i. Death of the recipient;

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

k. Medication errors;

l. Theft;

m. Medical Emergency; or

n. Suicide Threats or Attempts.

Q. 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.

R. Direct Marketing

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

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

1. the recipient must enroll with the provider in order to obtain benefits or in order not to lose benefits; or

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

S. Records

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

1. 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.

    a. The Provider must maintain all required records for each PCA employed by the agency, regardless of the length of employment.

    b. The Provider must maintain the required record for each recipient who has been provided services, regardless of length of the service period.

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

clearly documented as being provided on the service delivery records. This includes electronic service delivery records.

T. Documentation Requirements

In addition to all of the above responsibilities, if Self-Directed Skilled Services are provided it is the responsibility of the ISO to ensure all requirements of NRS 629.091 are met in order to receive reimbursement for these services. All required documentation must be made available to the DHCFP or its designee immediately upon request.

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

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

U. Discontinuation of Provider Agreement

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

   a. 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;

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

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

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

   a. 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.

b. 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.

V. As mandated by Nevada statute, federal law or any other applicable Medicaid authority, providers must adhere to all wage requirements established by federal or state law or applicable Medicaid requirements for direct care workers. Specific wage requirements are outlined in the State Plan Authority 4.19-B and adherence requirements are outlined in a provider's enrollment contract. The DHCFP Audit Unit will conduct audits to ensure compliance with any wage requirement. As part of these audits, documents requested may include but are not limited to:

1. payroll records such as timesheets or timecards;

2. detailed paystubs including hours and rates per direct care worker;

3. employment documentation used to verify identification and authorization to work;

4. financial records needed to verify a provider's wage expense.

If a provider is determined to not be in compliance with paying their direct care workers a required wage, a provider will be subject to corrective action. Initial violations for non-compliance may result in provider education as well as recoupment of overpayment due to a provider not paying a direct care worker the mandated wage. Continued violations may trigger corrective action including additional penalties up to termination.

2603.9 RECIPIENT RESPONSIBILITIES AND RIGHTS

A. Recipient Responsibilities

Participation in the SD service delivery option is completely voluntary and failure to comply with any of the responsibilities listed below may result in termination of the recipient's participation in this service delivery option.
The recipient, their LRI or PCR will:

1. notify the provider of changes in Medicaid or NCU eligibility.

2. notify the provider of current insurance information, including the carrier of other insurance coverage, such as Medicare.

3. notify the provider of changes in medical status, service needs, address and location or in changes of status of legally responsible individual(s) or PCR.

4. treat all staff appropriately.

5. agree to utilize an approved EVV system for the Medicaid services being received from the ISO.

6. confirm services were provided by electronically signing or initialing, as appropriate per service plan, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

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

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

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

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

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

12. recruit, interview, select, schedule, direct and dismiss PCAs.

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

14. verify services were provided according to the approved service plan and/or doctor's orders by, whenever possible, signing or initialing the PCA documentation of the exact date and time the PCA was in attendance and providing services.

15. inform the PCA of the existence of advance directive documents, if these are available, and provide a copy to the ISO, if appropriate.

16. notify the ISO and the recipient's case manager, if applicable, or the local DHCFP District Office when the recipient, their LRI or PCR no longer wish to self-direct their services and request care be provided through a provider agency.

17. cooperate with the DHCFP or its designee in conducting compliance reviews, investigations or audits.

18. specify any and all specialized training requirements of the PCA and assure that the

specified training has been received.

19. obtain re-certification for continued services according to policy. This may require that a FASP and/or a new authorization request for Self-Directed Skilled Services Form be completed.

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

20. The recipient, LRI and/or PCR are responsible to cooperate fully with the physician and other healthcare providers in order to establish compliance with the requirements set forth in NRS 629.091.

21. When the recipient desires to provide specialized training and is able to state and convey his/her own needs and preferences to the PCA, information must be documented in the recipient's file identifying the specific training the recipient has provided.

22. The authorization request for Self-Directed Skilled Services Form is required and must be completed by a qualified provider for each personal care assistant who will perform the skilled services.

B. Recipient Rights

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

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

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

3. participate in the development process and receive an explanation of authorized services;

4. receive a copy of the approved service plan;

5. contact the local DHCFP District Office, with questions, complaints, or for additional information;

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

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

8. 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;

9. receive information upon request regarding the DHCFP's policies and procedures, including information on charges, reimbursements, FASP determinations and the opportunity for fair a hearing;

10. request a change of provider;

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

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

13. receive upon request the telephone number of the Office for Consumer Health Assistance.

2603.10 ESCORT SERVICES

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

2603.10A COVERAGE AND LIMITATIONS

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

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

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

3. An LRI is unavailable or incapable of providing the personal care task en route to or during the appointment.

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

2603.10B AUTHORIZATION PROCESS

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

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

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

2603.10C PROVIDER RESPONSIBILITY

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

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

2603.11 TRANSPORTATION

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

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

2603.12 REIMBURSEMENT

Medicaid reimbursement is made directly to the Provider Agency for services billed using Service Code T1019 for PCS or T1019TF for SD Skilled. The reimbursement rate is based on a contracted rate which takes into consideration and includes the costs associated with doing business. Consequently, separate reimbursement is not available for the following: Time spent completing administrative functions such as supervisory visits, scheduling, chart audits, surveys, review of service delivery records and personnel consultant;

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

B. Travel time to and between recipients' home;

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

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

2603.13 IMPROPER BILLING PRACTICES

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

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

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

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

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 recipient's residence;

C. submitting claims for visits without documentation to support the claims billed.

1. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the recipient's signature, the month, day, year and time in and out of the recipient's home. Providers shall submit or produce such documentation upon request by the DHCFP staff;

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 submitting claims for PCS provided by an unqualified paid PCA.

F. submitting claims for PCS provided by an unqualified paid PCA.

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

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

2603.14 QUALITY ASSURANCE

The DHCFP and/or ADSD may conduct reviews, announced or unannounced, to evaluate the provider's compliance with this chapter and any other regulatory requirement.

These reviews may consist of, but are not limited to, a desk review by the DHCFP and/or ADSD staff and/or an onsite review. Providers must cooperate with the review process. Additionally, reviews may be conducted to verify that providers meet requirements established for each service, to ensure services are being provided and billed for accordingly and that claims for those services are paid in accordance with the State Plan, this chapter and all federal and state regulations.

Reviews may also be conducted to ensure the health and welfare, service satisfaction and freedom of choice of the recipients receiving PCS and/or Skilled Services.

2603.15 ADVERSE ACTIONS

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

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

A. the recipient is not eligible for Medicaid;

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

C. the recipient, their LRI or the PCR refuses services or is non-cooperative in the establishment or delivery of services;

D. the recipient, their LRI or the PCR refuses to accept services in accordance with the approved service plan;

E. all or some services are no longer necessary as demonstrated by the FASP;

F. the recipient's needs can be met by an 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 2603.1C.3);

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

2604 PCS INDEPENDENT CONTRACTOR (IC) MODEL

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

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

2604.1 COVERAGE AND LIMITATIONS

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

2604.1A AUTHORIZATION PROCESS

Prior authorization must be obtained before services can be provided. PCS is authorized by the ADSD case manager. The IC shall contact the recipient's ADSD case manager to obtain prior authorization for services.

2604.1B PROVIDER RESPONSIBILITIES

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

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

1. Provider Enrollment.

   To become a Nevada Medicaid provider, the IC must enroll with the QIO-like vendor as a PT 58, Specialty 189.

2. EVV

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

3. The following policies apply to the IC option:

a. The IC must verify Medicaid Eligibility monthly.

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

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

d. 24-Hour Accessibility.

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

e. Backup Mechanism.

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

f. Referral Source Agreement.

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

g. Administrative Functions

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

h. Service Initiation.

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

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

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

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

4. The procedure and form used to verify PCA attendance.

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

   a. Authorized service hours;

   b. PCA's schedule;

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

6. EVV requirements and recipient participation.

i. Supervision

The IC is not required to meet the supervisory requirement of the PCS agency. As an IC the provider is required to perform all PCA services and document all services in an approved EVV system.

j. Training

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

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

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

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

b. Body mechanics and transfer techniques;

c. Bathing, basic grooming and mobility techniques, including simple non-prescribed range of motion;

d. Personal care skills, including PCS permitted and not permitted (refer to Sections 2603.1C and 2603.8);

e. Care of the home and personal belongings;

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

g. Household safety and accident prevention, including information on general household safety and how to prevent accidents, poisoning, fires etc. and minimizing the risk of falls;

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

i. Bowel and bladder care, including routine care associated with toileting, routine maintenance of indwelling catheter drainage system (emptying bag, positioning, etc.), routine care of colostomies (emptying bag, changing bag), signs and symptoms of urinary tract infections and common bowel problems, such as constipation and diarrhea;

j. Skin care, including interventions to prevent pressure sores, (repositioning, use of moisturizers, etc.), routine inspections of skin, and reporting skin redness, discoloration or breakdown to the recipient or caregiver;

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

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

m. Communication skills, including basic listening and verbal communication skills, problem solving and conflict resolution skills, as well as alternative modes of communication techniques for individuals with communication or sensory impairments;

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

o. Directives, including information regarding the purpose of an advance directive and implications for the PCA.

k. Records

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

l. HIPAA, Privacy and Confidentiality

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

m. Notification of Suspected Abuse or Neglect

Reference Section 2603.8 of this chapter.

2604.1C RECIPIENT RESPONSIBILITIES

All of the policies discussed in the Section 2603.9 of this chapter apply to the IC model.

2605 HEARINGS

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

2606 SELF DIRECTED (SD) SKILLED SERVICES – CLINICAL DECISION SUPPORT GUIDE

Level I	Level II	Level III	Level IV	Level V
Not to exceed four hours a week	Not to exceed10 hours a week	Not to exceed 22 hours a week	Not to exceed 30 hours a week	Not to exceed 40 hours a week
+ Limited skilled interventions	**++One or two routine skilled** interventions, with or without limited skilled interventions.	**Three to five routine skilled** interventions, with or without limited skilled interventions; or	**Four to six routine skilled** interventions, with or without limited skilled interventions; or	**Seven routine skilled** interventions, with or without limited skilled interventions; or
		+++One highly complex skilled and one to two routine skilled intervention(s), with or without limited skilled interventions; or	**One highly complex skilled intervention and three to four routine skilled** intervention(s), with or without limited skilled interventions; or	**One highly complex skilled intervention and five to six routine skilled** interventions, with or without limited skilled interventions; or
		Two complex skilled interventions, with or without limited skilled services.	**Two highly complex skilled** interventions, with either **routine skilled** interventions or limited skilled interventions.	**Two highly complex skilled intervention and two to five routine skilled** interventions, with or without limited skilled interventions; or
				Three highly complex skilled interventions, with or without **additional routine skilled** interventions or limited skilled interventions.