Medicaid Services Manual
Transmittal Letter

October 29, 2024

To:	Custodians of Medicaid Services Manual
From:	Casey Angres *Casey Angres* Casey Angres (Jan 8, 2025 16:06 PST) 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 (PCS) Program 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: Unknown at this time.

Financial Impact on Local Government: Unknown at this time.

These changes are effective November 1, 2024.

Material Transmitted	Material Superseded
MTL 23/24 MSM Ch 3500 – Personal Care Services Program	MTL 25/23 MSM Ch 3500 – Personal Care Services Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3503.1H(22)	**Provider Responsibilities**	Language added to align with SB511 wage requirements.

PERSONAL CARE SERVICES (PCS) PROGRAM

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3500 INTRODUCTION

PERSONAL CARE SERVICES (PCS)

The objective of the PCS Program is to assist, support and maintain recipients living independently in their homes. PCS include a range of human assistance provided to persons with disabilities and chronic conditions of all ages, which enables accomplishment of tasks that they would normally do for themselves if they did not have a disability or chronic condition. These services are provided where appropriate, medically necessary and within service limitations. Services may be provided in settings outside the home, including employment sites.

PCS 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) or institutions for mental disease or other excluded settings.

Nevada Medicaid offers two distinct PCS delivery models: The Provider Agency Model or the Self-Directed Model.

This Medicaid Services Manual (MSM), Chapter 3500, contains Nevada Medicaid's policy for PCS provided through the Provider Agency service delivery model. For policy pertaining to the Self-Directed service delivery model, refer to MSM Chapter 2600.

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

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

3501 AUTHORITY

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, Section 12006 – 114th Congress
- H.R. 6042 – 115th Congress

3502 DEFINITIONS

Program definitions can be found in the MSM Addendum.

3503 POLICY

3503.1 PERSONAL CARE SERVICES (PCS)

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 needs 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.

Legally Responsible Individuals (LRIs) may not be reimbursed for providing PCS.

3503.1A 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, NF, ICF for 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 or Personal Care Representative (PCR) must be cooperative in establishing the need for the provision of services and comply with the approved service plan;

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

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

3503.1B 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, including 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 impact the recipient's ability to safely perform household tasks or meal preparation independently;

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

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

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;

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 Personal Care Attendant (PCA).

n. Any other service not listed under Section 3503.1.B.1.

3503.1C LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

LRIs 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. LRIs 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.

3503.1D PERSONAL CARE REPRESENTATIVE (PCR)

A recipient who is unable to provide direction in the delivery of 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.

The PCR must:

1. Effectuate, as much as possible, the decision the individual would make for himself/herself;

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

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

4. Understand that provision of services is based upon mutual responsibilities between the PCR and the provider agency.

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 3503.1I 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 provider agency and other care providers. The PCR must be available to the recipient, the provider agency and other care providers as necessary to fulfill the regular elements of Section 3503.1I 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 provider agency to make the necessary changes and obtain necessary form(s).

3503.1E 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 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 PCS Provider Agency.

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 Provider Agency 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 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 PCS Provider Agency 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 a 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 PCS Provider Agency 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 circumstance(s) that required the short term modification(s) of the approved service plan;

b. Documentation of the short-term modification(s) of the approved service plan must be completed and sent to the Provider Agency, 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, such as bowel or bladder incontinence. The Provider Agency must document the medical necessity of the service requested and be the designated provider for the current authorization period. The request should 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 PCS Agency providers, except in hardship situations in remote or rural areas of the state where failure to reimburse mileage expenses would severely limit available PCS Agency 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.

3503.1F FLEXIBILITY OF SERVICES 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 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 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.

3503.1H 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. 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.

22. 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 Division will conduct audits to ensure compliance with any wage requirement. As part of these audits, documents requested may include but are not limited to:

a. payroll records such as timesheets or timecards;

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

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

d. 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.

3503.1I 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;

d. Treat all staff appropriately;

e. Agree to utilize an approved EVV system for the Medicaid services being received from the Provider Agency.

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

g. Notify the Provider when scheduled visits cannot be kept or services are no longer required;

h. Notify the Provider of missed visits by provider staff;

i. Notify the Provider of unusual occurrences or complaints;

j. Give the Provider a copy of an Advance Directive, if appropriate;

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

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

m. Not request a PCA to work or clean for non-recipients;

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

2. Recipient Rights

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

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

b. Participate in the assessment process and receive an explanation of authorized services;

c. Receive a copy of the approved service plan;

d. Contact the local DHCFP District Office with questions, complaints or for additional information;

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

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

g. Expect all providers, within the limits set by the approved service plan and within program criteria, to respond in good faith to the recipient's reasonable requests for assistance;

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

i. Request a change of provider;

j. Request a change in service delivery method from the Provider Agency model to the Self-Directed model through an Intermediary Service Organization (ISO);

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

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

m. Receive, upon request, the telephone number of the Office for Consumer Health Assistance.

3503.2 PCS 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, PCS are available to supplement those support systems so the child is able to remain in the home. LRIs may not be reimbursed by Medicaid.

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.

3503.3 PCS FOR RECIPIENTS ENROLLED IN HOSPICE

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

If a recipient enrolls in hospice, the DHCFP or its designee will conduct an evaluation of an individual's comprehensive personal care needs 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 total personal care needs. PCS provided under hospice will be subtracted from the total authorized PCS.

The PCS provided by a PCA to a recipient because of needs unrelated to the terminal condition may not exceed program limits and guidelines.

3503.4 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 supported living arrangement (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.

3503.5 ESCORT SERVICES

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

3503.5A 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.

3503.5B AUTHORIZATION PROCESS

1. The provider must contact the QIO-like vendor, the ADSD or Waiver for Persons with Physical Disabilities DHCFP case manager, as appropriate, for prior authorization for escort services.
2. Service should be requested as a single service authorization request. The provider must document the medical necessity of the services.
3. A new FASP is not required in this situation.

3503.5C PROVIDER RESPONSIBILITY

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

B. 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 3503.1E.

C. All services must be documented and verified in an approved EVV system.

3503.6 TRANSPORTATION

Transportation of the recipient in a provider's vehicle, 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. Nevada Medicaid provides necessary and essential medical transportation to and from medical providers.

3503.7 REIMBURSEMENT

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

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

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

C. Travel time to and between recipient's home;

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

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

3503.8 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 month, day, year and exact 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

F. Submitting claims for PCS services 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.

3503.9 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 requirements.

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 the 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.

3503.10 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 PCR or LRI refuses services or is non-cooperative in the establishment or delivery of services;

D. The recipient, their PCR or their LRI 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 Section 3503.1B); or

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

3504 HEARINGS

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