SECTION 13 - BENEFITS AND LIMITATIONS

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13.1 GENERAL INFORMATION

The Missouri Title XIX (Medicaid) Personal Care Program offers medically related services designed to meet the maintenance needs of recipients with a chronic, stable condition. Available services include basic and advanced personal care aide services and authorized nurse visits.

The purpose of the authorized nurse visit is to provide increased supervision to the personal care aide, intensified health care assessment of the participant, and, in some cases, certain nursing services that do *not* meet the requirements for reimbursement under either the Medicare or MO HealthNet Home Health Programs. The authorized nurse visit is used for advanced personal care plan development, on-the-job training for the advanced personal care aide, and monthly evaluation of advanced personal care recipients.

A description of the services and requirements of this program is included later in this section.

The information contained in this section is *not* applicable to the Consumer-Directed Personal Assistance Programs administered by the Department of Elementary and Secondary Education/Division of Vocational Rehabilitation. Reference 13 CSR 70-91.030, 5 CSR 90-7.010, 5 CSR 90-7.100, 5 CSR 90-7.200, 5 CSR 90-7.310, 5 CSR 90-7.320, and the Division of Vocational Rehabilitation's *PAS Programs Manual* for information regarding the Consumer-Directed Personal Assistance Programs.

13.1.A SERVICE DEFINITION

Personal care services are medically oriented tasks that are reviewed and approved or certified by a physician as the home care necessary to meet a participant's physical needs and thereby enable the participant to remain in his or her home and be treated on an outpatient basis rather than in a hospital or nursing facility. The requirement of physician's approval versus physician's certification is dependent upon which client group (e.g., elderly, children, etc.) the personal care services are being authorized for. Reference the authorization section applicable to each client group. For purposes of the Personal Care Program, the term "home" includes recipients residing in Residential Care Facilities I or II. These services *must* be reasonable and necessary for the treatment of a medical condition and *must* maintain or increase the functional capacity of the participant. Personal care services are intended to meet personal, physical requirements, as opposed to general housekeeping requirements, and to meet needs that *cannot* be met by other resources. Personal care services covered by the Missouri Title XIX (Medicaid) Program *must* be provided by a qualified individual who is *not* a member of the participant's family or household.

NOTE: A family member is defined as a parent; sibling; child by blood, adoption, or marriage; spouse; grandparent; or grandchild.

13.1.B PERSONAL CARE TASKS

Examples of personal care services that may be performed are:

- Planning, preparation, and clean-up of meals;
- Making beds and changing sheets with the participant in or out of the bed, as required;
- Brushing, combing and shampooing hair;
- Giving bed baths and assisting with other baths;
- Brushing teeth and cleaning dentures when the participant is unable;
- Cleaning and cutting fingernails and toenails of recipients without contraindicating conditions;
- Shaving with an electric or safety razor, as appropriate; an electric razor *must* be used for the diabetic participant or participant with contraindicating conditions;
- Giving assistance to and from the bed to a wheelchair, walker or chair when a participant is weight bearing;
- Assisting the participant with ordinarily self-administered medications (open bottles, get water);
- Shopping for groceries or household items specifically required for the health and maintenance of the participant; and
- Applying non-prescription topical ointments/lotions to unbroken skin at the participant's direction.

The encouragement and instruction of recipients in self-care may be a component of any other task(s) as described above; however, encouragement and instruction do *not* constitute a task in and of themselves.

Advanced personal care services provide assistance with activities of daily living when such assistance requires devices and procedures related to altered body functions. These services are described in greater detail later in Section 13.9.

13.1.C SERVICE LIMITATIONS

Personal care services are covered only in the participant's home; by definition, this includes Residential Care Facilities I and II. These services are *not* covered in a hospital or nursing facility. The only acceptable place of service code to use when filing claims is 12 (Home).

Personal care providers are *not* reimbursed for the following activities:

- Providing therapeutic/health-related activities that should be performed by an RN, LPN, or home health aide under Title XVIII or Title XIX Home Health Programs;
- Providing transportation or escort services;
- Administering patent or prescribed medications;
- Cleaning or cutting fingernails or toenails of a diabetic participant or a participant with circulatory problems, unless this service is performed by a nurse during an authorized nurse visit;
- Cleaning the floor and furniture in areas *not* occupied by the participant. For example, cleaning the entire living area if the participant occupies only one small room;
- Laundry, other than that incidental to the care of the participant. For example, laundering clothing and bedding for the entire household, as opposed to simple laundering of the participant's bed smock or gown;
- Shopping for groceries or household items other than items required specifically for the health and maintenance of the participant. This does *not* preclude a personal care aide's shopping for items needed by the participant, but also used by the rest of the household;
- Providing personal care services to a participant by a member of the participant's family or household member; and
- Performing or furnishing out-of-state personal care services.

13.1.D PROVIDER PARTICIPATION

The provider of personal care services *must* have a valid MO HealthNet Personal Care Provider Agreement in effect with the Department of Social Services (DSS), MO HealthNet Division (MHD). The applicant *must* be one of the following to enroll.

- An approved Department of Health and Senior Services, Division of Senior Services and Regulation Title XX Social Services Block Grant (SSBG) provider. Providers *must* maintain their approval to participate as a Title XX provider, whether or not they actually service Title XX eligible clients, in order to remain qualified to participate in the Title XIX (Medicaid) Personal Care Program.
- A Residential Care Facility (RCF) I or II provider, licensed by the Department of Health and Senior Services, Division of Senior Services and Regulation. RCF personal care providers may only furnish personal care services to recipients in their RCF. MO HealthNet RCF personal care providers *must* maintain their RCF license in

order to remain qualified to participate in the Title XIX (Medicaid) Personal Care Program.

13.1.E PARTICIPANT ELIGIBILITY FOR PERSONAL CARE SERVICES

Eligibility for personal care services requires current eligibility for MO HealthNet. In addition to being MO HealthNet eligible, the participant *must*:

- be assessed by the appropriate state agency (reference Section 14.1) to have certain impairments and unmet needs, such that the participant would require admission to a hospital or a long term care facility if personal care services were *not* provided; and
- be willing to receive comprehensive assessment and case management services from the involved state agency.

General Relief recipients age 21 and over are *not* eligible to receive personal care services reimbursed through the MO HealthNet Program. General Relief recipients can be identified while verifying eligibility. Reference Section 1 for further information.

The participant *must* be eligible for MO HealthNet services on the day the service is delivered, or the provider will *not* be reimbursed through MO HealthNet. This is a requirement even when the service has been prior authorized. It is the responsibility of the provider to verify eligibility by contacting the interactive voice response unit (IVR) system at (573) 635-8908 or through a point of service (POS) terminal on the day the service is provided, to determine that the participant is eligible as of that date.

13.1.F AUTHORIZATION OF PERSONAL CARE SERVICES

All units of Title XIX personal care services *must* be authorized by a state agency case manager before services can be delivered. Following development of a care plan and its approval or certification by the participant's physician, a set of documents is sent to the provider. The physician is sent a copy of the plan of care for review. This allows the physician to review and contact the authorizing agency or the provider of care with concerns. These may include the following:

- Intake/Screening or other document with identifying information;
- Initial Plan of Care;
- Authorization for Services; and
- Service Authorization Supplement, or list of activities to be performed.

The authorization for services shows how many units of service are authorized and specifies the period of time covered by the authorization.

The service authorization supplement is a checklist that shows the specific service activities that *must* be performed, at a minimum, by the personal care worker. Additional service activities may be performed as long as the time spent does *not* exceed the time (units) authorized.

More information about documentation is contained in Section 14 of this Manual.

13.2 ADMINISTRATION

13.2.A PARTICIPATION AND NOTIFICATION REQUIREMENTS

The following administrative standards *must* be followed whenever personal care services or authorized nurse visits are being delivered.

- Each participating provider *must* have a valid provider agreement in effect with the MO HealthNet Division to provide personal care services.
- The provider shall immediately notify the appropriate state agency case manager and the MO HealthNet Division Provider Enrollment Unit of any changes in location, telephone number, administrative or corporate status.
- The provider shall notify the agency and the MO HealthNet Division at least 30 days prior to the termination of the provider agreement.

13.2.B PERSONNEL—GENERAL ADMINISTRATIVE REQUIREMENTS

- The provider *must* document all staff qualifications in the personnel records, such as verification of the registered nurse or licensed practical nurse license, or certified nurse aide license, which should include at least the license number.
- The provider shall maintain documentation of at least two employment or personal references contacted for each personal care aide within 30 calendar days before or after the date of employment. References shall be former employers or other reputable persons, excluding relatives of the personal care aide.
- The provider shall establish, implement and enforce a policy governing communicable diseases that prohibits provider staff contact with clients when the employee has a communicable condition, including colds or flu. Ensure that reporting requirements governing communicable diseases, including hepatitis and tuberculosis, as set by the Missouri Department of Health and Senior Services (19 CSR 20-20.020), are carried out.
- The provider *must* have an established grievance system through which a participant may present grievances concerning the operation of the in-home service program. The

provider *must* document the participant's receipt of information regarding the grievance procedures.

- The provider *must* protect the Departments of Social Services and Health and Senior Services and their employees, agents or representatives from any and all liability, loss, damage, cost and expense which may accrue or be sustained by the Department of Social Services, its officers, agents or employees as a result of claims, demands, costs, suits or judgments against it arising from the loss, injury, destruction or damage, either to person or property, sustained in connection with the performance of the in-home service.
- Providers *must* establish, enforce and implement a policy whereby all contents of the personnel files of its employees are made available to Departments of Social Services and Health and Senior Services employees or representatives when requested as part of an official investigation of abuse, neglect, financial exploitation misappropriation of client's funds or property or falsification of documentation which verifies service delivery.
- The provider shall maintain bonding and personal and property liability insurance coverage on all employees who are involved in delivering personal care services.
- The provider *must* monitor a current copy of the Department of Health and Senior Services Employee Disqualification List (EDL) to ensure that no current or prospective employee's name appears on the list. The provider *must* also make an inquiry with the Division of Senior Services and Regulation as to whether a prospective employee is on the EDL. This may be done by calling (573) 526-3633 or (573) 526-8563. The provider *must* take the appropriate action once it is discovered by the provider that the current employee is on the Employee Disqualification List. If it is found that a prospective employee is on the List, then that employee should *not* be considered further for employment.
- The provider *must* issue to each personal care aide, at time of employment, a permanent identification card that shows the provider's name and the aide's name, title, and signature. The provider shall require each personal care aide to carry the identification card to present to recipients as necessary. The provider shall make every effort to repossess the I.D. card upon termination of employment. If unable to do so, the provider *must* retain on file a statement describing what efforts were made to recover the I.D. card.

13.2.C PROVIDER SERVICE DELIVERY STANDARDS

- The provider *must* have the capability to provide service outside of regular business hours, on week-ends, and on holidays to provide services in accordance with the

Authorization for Service for each participant. Service *must* be provided by qualified persons on the provider's staff.

- Providers shall accept participants on the basis of a reasonable expectation that the participant's maintenance care needs can be met adequately by the agency in the participant's place of residence. Services *must* follow the written plan of care .
- The provider *must* deliver the personal care services within seven calendar days of receipt of the service authorization or on the beginning date specified by the authorization, whichever is later, and on a regular basis thereafter in accordance with the service plan. The date of receipt *must* be stamped on each service authorization by the provider. If service is *not* initiated within the required time period, a detailed written justification *must* be maintained in the participant's file and sent to the state agency case manager.
- The personal care provider *must* report all instances of potential abuse, neglect, and/or exploitation of a participant to the appropriate state agency, including all instances that may involve an employee of the provider agency.

13.2.D PARTICIPANT'S RIGHTS AND PROCEDURES

The provider shall have a written statement of the participant's rights which is to be given to each participant and primary caregiver, when appropriate, at the time service is initiated, which includes, at a minimum, the right to:

- be treated with respect and dignity;
- have all personal and medical information kept confidential;
- have direction over the services provided, to the degree possible, within the service plan authorized;
- know the provider's established grievance procedure, how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution;
- receive service without regard to race, creed, color, age, sex or national origin; and
- receive a copy of the code of ethics under which services are provided.

13.2.D(1) Participant Nonliability

MO HealthNet covered services rendered to an eligible beneficiary are *not* billable to the beneficiary if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

For questions regarding the Personal Care Program, call the Provider Relations Communication Unit's number (573) 751-2896.

13.2.D(2) Participant Cost Sharing and Copay

Recipients eligible to receive certain MO HealthNet services are required to pay a small portion of the cost of the services. Services of the Personal Care Program described in this manual are *not* subject to a cost sharing or copay amount.

13.2.E DISCHARGE POLICIES AND PROCEDURES

Services for a client shall be discontinued by a provider agency under the following circumstances:

- When the client's case is closed by the state agency;
- When the provider learns of circumstances that require the closure of a case for reasons including, but *not* limited to: death; entry into a nursing home; or the client no longer needs services. In these circumstances, the provider shall notify the state agency case manager in writing and request that the client's services be discontinued;
- When the client is noncompliant with the agreed upon plan of care. Noncompliance requires persistent actions by the client or family which negate the services provided by the agency. After all alternatives have been explored and exhausted, the provider shall notify the state agency case manager in writing of the noncompliant acts and request that the client's services be discontinued;
- When the client or client's family threatens or abuses the personal care aide or other agency staff to the point where the staff's welfare is in jeopardy and corrective action has failed. The provider shall notify the state agency case manager of the threatening or abusive acts and may request that the service authorization be discontinued.
- When a provider is unable to continue to meet the maintenance needs of a client. In these circumstances, the provider shall notify the state agency case manager in writing and request that the client's services be discontinued; or
- When a provider is unable to continue to meet the maintenance needs of a client whose plan of care requires advanced personal care services. In these circumstances the provider shall provide written notice of discharge to the client or client's family and the state agency case manager at least 21 days prior to the date of discharge. During this 21 day period, the state agency case manager shall assist in making appropriate arrangements with the client for transfer to another agency, institutional placement or other appropriate care. Regardless of circumstances, the personal care provider *must* continue to provide care in accordance with the plan of care for these 21

days or until alternate arrangements can be made by the case manager, whichever comes first.

Discontinuing services for a client still in need of assistance shall occur only after appropriate conferences with the state agency case manager, client and client's family.

13.2.F NONDISCRIMINATION

Providers *must* comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable Federal and State Laws that prohibit discrimination in the delivery of services on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs.

Further, all parties agree to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap/disability, and religious beliefs.

13.2.G PROVIDER COMPLIANCE

The Departments of Social Services and Health and Senior Services or their designee conducts both program and fiscal monitoring of the in-home services program. Monitoring visits may be announced or unannounced. The providers *must* agree to comply with any evaluation conducted by the Departments of Social Services and Health and Senior Services. The Division of Senior Services and Regulation may, in accordance with the protective service mandate (RSMo Chapter 660), take action to protect clients from providers who are found to be out of compliance with the requirements of its regulations and of any other regulations applicable to the Personal Care Program, when such noncompliance is determined by the Division of Senior Services and Regulation to create a risk of injury or harm to clients. Evidence of such risk may include: unreliable or inadequate provider documentation of services or training due to falsification or fraud; the provider's failure to deliver services in a reliable and dependable manner; or use of personal care aides who do *not* meet the minimum training standards of this regulation. Immediate action by the Division of Senior Services and Regulation may include, but is *not* limited to:

- Removing the provider from any list of providers, and for clients who request the unsafe and noncompliant provider, informing the clients of the determination of noncompliance, after which any informed choice will be honored by the Division of Senior Services and Regulation; or
- Informing current clients served by the provider of the provider's noncompliance and that the Division of Senior Services and Regulation has determined the provider

unable to deliver safe care. Such clients are allowed to choose a different provider from the list maintained by the Division of Senior Services and Regulation, which is then immediately authorized to provide service to them.

13.3 PERSONNEL

13.3.A ADMINISTRATIVE SUPERVISOR QUALIFICATIONS

A personal care administrative supervisor shall be designated by the provider ownership or administrative management to supervise the day to day delivery of direct personal care services. This position of responsibility may be assigned in conjunction with other duties within the provider organization.

The designated administrative supervisor shall be at least 21 years of age. In addition, the supervisor *must* meet at least one of the following criteria before performing the supervisory duties required by these standards. The supervisor *must*:

- be a registered nurse (RN) licensed in the state of Missouri; or
- have a baccalaureate degree; or
- be a licensed practical nurse (LPN), licensed in the state of Missouri with at least one year of experience with the direct care of the elderly, disabled, or infirm; or
- have three years of experience in the care of the elderly, disabled or infirm.

If the designated administrative supervisor is *not* a registered nurse (RN), the provider agency shall have an RN on staff or employed as a consultant available to fulfill the specific functions described later in this section. The RN *must* be currently licensed in the state of Missouri.

13.3.B PERSONAL CARE AIDE REQUIREMENTS

All basic personal care aides employed by the provider *must*:

- be at least 18 years of age;
- be able to read, write and follow directions; and
- have at least six months paid work experience as an agency homemaker, nurse aide, maid or household worker, or at least one year of experience in caring for children or for sick or aged individuals. Successful completion of formal training in the nursing arts, such as a nursing aide or home health aide, may be substituted for the qualifying experience. Advanced personal care aides *must* have additional qualification, as discussed in Section 13.9.

13.4 SUPERVISION

13.4.A GENERAL ADMINISTRATIVE DUTIES

The duties of the designated supervisor include the following:

- Read a copy of the MO HealthNet Program requirements contained in Section 13 of the provider manual. All nursing staff (registered nurses and licensed practical nurses) and administrative supervisors *must* have documentation in their personnel files that they have been given and have read this section.
- Monitor the provision of personal care services and authorized nurse visits to ensure that services are delivered in accordance with the services authorized by the appropriate state agency. This shall include routine review and comparison of the aides' records of provided services with the service authorizations for each participant. The units of service authorized, the tasks specified, and the authorized frequency of delivery *must* be compared to the units, tasks, and frequency of delivered services. A written explanation of any discrepancies and description of corrective action taken *must* be signed and dated by the supervisor and be readily available for monitoring or inspection. This requirement shall be met by a supervisory monitoring/delivery log document, (refer to Section 14.2) which *must* be completed monthly. One log for each county served shall be sent to the Division of Senior Services and Regulations' Regional Manager or the Bureau of Special Health Care Needs office in charge of care coordination for that participant whose region includes the counties served. It is due by the thirtieth day of each month immediately following the month of the log. A copy of each log shall be kept by the provider and be available for monitoring, upon the request by the Departments of Social Services or Health and Senior Services. Refer to Section 14 for more information regarding this document.
- Complete a written evaluation of each personal care aide's performance at least annually. The evaluation *must* be based in part on at least one on-site visit. The on-site visit also includes an evaluation of the adequacy of the service plan, including review of the plan of care with the participant. The aide *must* be present during the visit, and documentation *must* be provided to indicate the aide's presence. The written report of the evaluation should document the visit, containing the participant's name and address, the date and time of the visit, the aide's name, and the supervisor's observations and notes from the visit. In addition to information from the on-site visit, the written evaluation should contain sufficient other data on the aide's performance to demonstrate that the evaluation was based on qualified observation. The written evaluation should show what support and supervision has been provided to the aide and what support, supervision, and other intervention is planned as a result of the

evaluation. The evaluation *must* be signed and dated by the supervisor who prepared it and by the aide.

The written record of the evaluation shall be maintained in the personnel file of the personal care worker. If the required evaluation is *not* performed or *not* documented, the personal care worker's qualifications to provide the service may be presumed inadequate and all payments made for services by that personal care worker may be recouped. Unless, medically, the participant's condition supports a visit or all recipients have been visited, a service participant shall *not* receive more than one combined on-site supervisory visit and on-site RN visit per state fiscal year.

- Assist in orientation and personal care training for personal care workers.
- Designate a trainer(s) to perform the four-hour on-the-job training sessions required as part of the basic training of the personal care aide. (Refer to Section 13.6.) The designated trainer(s) may be the personal care supervisor or a personal care aide who has been employed by the provider agency at least half-time for a period of six months. Exceptions to the required six-month period of employment may be made on a case-by-case basis through the central offices of the appropriate state agency and Division of Medical Services. A list of designated trainers and documentation of any exceptions waiving the required length of employment *must* be available for monitoring.
- Communicate with the state agency case manager regarding changes in any participant's condition and recommended changes in scope or frequency of service delivery. The appropriate form should be used to transmit and document such communication. Either the personal care aide or the personal care supervisor may complete and return the form to the state agency case manager.
- Be available for regular case conferences with the appropriate state agency case manager.

13.5 NURSE SUPERVISION REQUIREMENTS

13.5.A PARTICIPANT SAMPLING

Registered nurse supervision of personal care services is a requirement of the MO HealthNet Personal Care Program. Each MO HealthNet provider agency *must* have an RN available to perform specific supervisory functions. While some of the nursing supervision functions may be delegated to a licensed practical nurse, as described in this section, the provider agency is still responsible for having registered nurse staff available to perform specified supervisory tasks. Depending upon the size and administrative structure of the provider agency, the

registered nurse may also be the designated administrative supervisor, described in Section 13.3.A.

To meet this supervisory responsibility, a monthly home visit shall be made to a 10% sample of the provider agency's combined Title XIX and Title XX caseload size as of the beginning of each month, except that no more than 30 visits and no less than 2 visits are required. This 10% sample is to exclude personal care and advanced personal care recipients receiving authorized nurse visits and on-site supervisory visits during that same month unless all recipients have been seen or the participant's condition supports a visit. The agency should develop sampling methods to ensure that as many individuals as possible may be seen during the course of a year. Providers should avoid choosing the same recipients for a supervisory visit month after month unless their level of care needs warrant frequent supervisory visits. The RN shall visit the participant at home or determine that an LPN will make the visit based upon the types of personal care services authorized in the participant's plan of care.

The RN has the responsibility of evaluating the adequacy of the plan of care in meeting the participant's needs, and shall include a review of the plan of care with the participant and assessment of the personal care worker relative to his/her ability to carry out the plan of care.

Written notes concerning the on-site visit *must* be maintained in the recipients case record. In addition, the RN *must* keep an on-site visiting log that lists, for each visit, the service participant's name, address, the date of the visit, the personal care worker's name and observations of both the personal care worker's performance and the adequacy of the service plan.

If the provider agency's administrative supervisor is *not* an RN, the staff RN or the RN consultant shall initial and review all on-site visit reports made by the administrative supervisor.

An LPN may perform the supervisory activities described in this section if under the direct supervision of an RN. The RN *must* review all written reports of the LPN and provide consultation to the LPN as needed.

13.6 TRAINING

All personal care aides, whether basic or advanced personal care aides, who provide services reimbursed by MO HealthNet *must* meet or have met the basic training and in-service training standards set forth in this section. Advanced personal care aides have additional training requirements, discussed under Advanced Personal Care in Section 13.9.

13.6.A DOCUMENTATION OF BASIC AND IN-SERVICE TRAINING

The provider shall have written plans for basic and in-service training of the personal care aide. These plans should include content for sessions. The plans should be updated as needed, to reflect the training needs of the provider agency's personal care aides, as well as, to incorporate any changes in the standards for Title XIX services.

The provider *must* maintain a report of each individual personal care aide's training in that aide's personnel record. The report *must* document the dates, hours and location of classroom and on-the-job training, the trainer's name, the topics, the date of first client contact, and the aide's signature. Participant contact may be either supervised on-the-job training or unsupervised service delivery. If a waiver of basic training has been granted, the personal care aide's individual training report shall contain supportive data for the waiver.

Other required documentation includes a topical outline of each session's content, the mode of training (classroom or on-the-job), and the signature of the attendee(s). Deviations in content from the written plan should be noted and explained.

The documentation referenced in the above paragraph may be maintained in a master training log or may be filed in each personal care aide's personnel file. The documentation *must* be readily available for monitoring or inspection by the Departments of Social Services and Health and Senior Services.

13.6.B BASIC TRAINING

When individuals are employed as personal care aides, they shall receive a minimum of 20 hours of basic training. The following requirements apply to this training.

- All basic training *must* be completed within 30 days of first day of participant contact.
- 8 hours of classroom training *must* be completed prior to first participant contact.
- 2 hours of basic training *must* include orientation to the provider agency and the agency's protocols for handling emergencies.
- 4 hours of basic training *must* include supervised on-the-job training under the direction of the designated trainer.
- Reading materials shall constitute no more than 2 of the total 20 hours.

13.6.B(1) Code of Ethics

As part of basic training, the provider shall distribute to all personal care aides a code of ethics. The code of ethics shall forbid, at a minimum, the following actions:

- Using the participant's car;
- Consuming the participant's food or drink (except water);
- Using the participant's telephone for personal calls;
- Discussing own or others' personal problems or religious or political beliefs with the participant;
- Accepting gifts or tips;
- Bringing other persons to the participant's home;
- Consuming alcoholic beverages, or using medicine or drugs for any purpose, other than medical, in the participant's home or prior to service delivery;
- Smoking in the participant's home;
- Soliciting or accepting money or goods for personal gain from the participant;
- Breaching the participant's privacy and confidentiality of information and records;
- Purchasing any item from the participant even at fair market value;
- Assuming control of the financial and/or personal affairs of the participant or of his/her estate including power of attorney, conservatorship, or guardianship;
- Residing with the participant in either the participant's or personal care aide's residence;
- Taking anything from the participant's home; and
- Committing any act of abuse, neglect, or exploitation.

13.6.B(2) Training Contents

Basic training for all personal care staff shall include at least the following:

- Organization, purpose and philosophy of the personal care provider;
- Relationship of the provider to the appropriate state agency and the Division of Medical Services;
- Code of ethics;
- Activities which shall and shall *not* be performed under the standards for personal care services;

- Basic first aid and procedures to be followed in an emergency;
- Information about record-keeping and report forms required by the standards;
- Techniques in basic personal care activities;
- Techniques in food preparation, nutritional requirements, and basic sanitation practices;
- Household management and home maintenance skills, as they relate to personal care;
- Safety precautions and recognition of job hazards;
- Information about the availability of other community resources;
- Occupational Safety Hazards Act (OSHA) standards regarding precautions to be taken to avoid risks associated with bloodborne pathogens; and
- Review of infection control and universal precaution procedures as defined by the Centers for Disease Control.

13.6.C WAIVER OF BASIC TRAINING

13.6.C(1) Experience or Aide Certification

The provider *must* supply 8 hours of classroom training, but may waive the additional 12 hours of the personal care aide's basic training with adequate documentation in the employee's records that the employee has received similar training during the current or preceding state fiscal year, or has been employed as an aide in an in-home or home health agency at least half-time for six months or more within the current or preceding state fiscal year. The eight hours of classroom training *must* include two hours of provider agency orientation.

13.6.C(2) Licensed Nurse/Certified Nurse Aide (CNA)

All basic training requirements, except a minimum two hour provider agency orientation may be waived, with documentation in the aide's personnel record that the aide is a registered nurse, licensed practical nurse or certified nurse aide.

13.6.C(3) Provider Verification

It is ultimately the provider's responsibility to judge whether or not the previous training was sufficient to justify a waiver. If the training is waived, the provider should obtain adequate documentation about the employee's previous training. The

provider may obtain written or phone verification of the previous training which includes at least the following:

1. The name, address, and phone number of the employer from whom the training was received.
2. The date or dates of the training.
3. A summary of the content and number of hours of the training.
4. For phone verification, the date of the phone contact, and the name of the person verifying the training information.

13.6.D JOB PERFORMANCE REVIEW

The job performance review shall consist of the personal care supervisor's observation of the aide's performance of hands-on personal care tasks. This review may take place during an on-site visit to a participant or in a classroom demonstration and *must* be performed within 30 days of the first date of employment.

The job performance review *must* include observed demonstration of at least three of the following personal care tasks:

- Making beds and changing sheets with the participant in the bed;
- Brushing, combing and shampooing hair;
- Giving bed baths and assisting with other baths;
- Giving assistance to and from the bed to a wheelchair, walker or chair when a participant is weight bearing;
- Cleaning and cutting fingernails and toenails of recipients without contraindicating conditions;
- Applying non-prescription topical ointments/lotions to unbroken skin at the participant's direction.

The personal care supervisor *must* document that the aide can successfully perform each of the demonstrated tasks. This documentation *must* be filed in the aide's personnel record.

13.6.E IN-SERVICE TRAINING

All personal care aides shall receive a total of 10 hours of in-service training annually after the first 12 months of employment.

At least six hours of the required ten hours shall be classroom instruction. The additional four hours may use any appropriate training method. A training hour is 60 minutes.

The provider may waive the required annual in-service training hours, and require only two hours of refresher training annually, when the aide has been employed for 3 years and has completed 30 hours of in-service training that meets the standards set forth in this section. This waiver shall be adequately documented and noted in the personal care aide's records.

Training should be conducted by the provider staff, as well as, by professionals available from other agencies such as the University Extension Service, County Health Departments, Red Cross, or other community resources. Training shall reinforce and extend the content of basic training. Training should include topics such as:

- Processes and effects of aging;
- Problem identification and procedures for making appropriate referrals;
- Non-medical personal care of the incapacitated participant;
- Techniques for assisting the participant with impaired mobility;
- Meal preparation for special diets;
- Home management and budgeting;
- Comparison shopping techniques;
- Problems common to the elderly and disabled;
- Recognizing and reporting abuse or neglect;
- AIDS education; and
- Death and dying.

13.7 RECORDS

The personal care provider shall document implementation of requirements for the following, as applicable:

- Coordination with other providers;
- Non-discrimination on basis of disabilities; and
- Administrative policies and procedures.

13.7.A PARTICIPANT CASE RECORD

The provider shall maintain a participant case record including records of service provision for each participant. The participant record is confidential and shall be protected from damage, theft, and unauthorized inspection. It shall be maintained in a central location, and shall contain at least the following:

- The Authorization for Services form and the Service Authorization Supplement Form, which documents authorization for all units of service provided;
- The participant's service log sheets, which *must* contain the personal care aide's name, the participant's name, dates of service delivery, time spent and activities performed on each date, and the participant's signature for each date of service. If the participant cannot write, his or her mark (X) shall be witnessed by at least one person who may be the personal care aide. Another responsible person, present in the home while the service is delivered, may sign the service log for each date of service. Each provider agency may design its own service log sheet, but all paid units of service *must* be documented. If these documents are *not* maintained in the participant's case record, they *must* be maintained in an area that is readily available for monitoring or inspection by the Departments of Social Services and Health and Senior Services;
- Documentation of undelivered services;
- The RN's written notes concerning any on-site visits made to the participant. Refer to Section 13.5.A
- Documentation of all correspondence and contacts with the participant's physician or other care providers;
- Copies of any Provider Feedback Reports transmitted to the state agency case manager;
- Any other pertinent documentation regarding the participant. Refer to Sections 13.8.D and 13.9.G(2); and
- Documentation that prior to initiation of service the participant was informed of their rights under the Advanced Health Care Directive. Documentation should include whether an Advanced Health Care Directive was executed by the participant. For more information concerning Advanced Health Care Directive, please reference Section 21.

13.7.B PERSONNEL RECORD

The provider *must* maintain an individual record for each personal care aide. A personnel record is a confidential record and shall be protected from damage, theft and/or unauthorized inspection. An individual personnel record shall include, at a minimum, the following:

- Employment application with the personal care aide's signature showing date of birth, education, work experience, and the date employed and terminated by the service provider;
- For supervisory staff, documentation that they have been provided with and have read Section 13.3.A of this provider manual;

- Documentation of at least 2 references contacted;
- Documentation of basic and in-service training received (individual training report; reference Section 13.6.A);
- Documentation of any waiver or reduction of employment or training requirements (reference Section 13.6.C);
- Annual performance evaluation which includes observations from at least one on-site visit (reference **Section 13.4)**;
- Signed statement(s) verifying that the personal care aide received a copy of the participant's rights and the code of ethics, and that the provider's policy regarding confidentiality of participant information was explained prior to service delivery;
- Statement identifying the personal care worker's position, including whether the employee performs administrative duties for the provider or delivers services to recipients; and
- Returned I.D. card for a terminated personal care worker, or documentation of why it is *not* available.

The provider *must* also maintain the written plans for basic and in-service training (Section 13.6), and the supervisor's and the RN's on-site visiting log (Section 13.4.A).

13.7.C RETENTION OF RECORDS

MO HealthNet providers *must* retain for 5 years, from the date of service, fiscal and medical records that coincide with and fully document services billed to the MO HealthNet Agency, and *must* furnish or make the records available for inspection or audit by the Departments of Social Services and Health and Senior Services or their representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to the MO HealthNet Program may result in recovery of the payments for those services *not* adequately documented and may result in sanctions to the provider's participation in the MO HealthNet Program. This policy continues to apply in the event of the provider's discontinuance as an actively participating MO HealthNet provider through change of ownership or any other circumstance. The provider *must* make records available for unannounced inspections and audits, with access during normal business hours by the Departments of Social Services and Health and Senior Services or the U.S. Department of Health and Human Services.

13.7.D ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3.030, Section(1)(A) defines "adequate documentation" and "adequate medical records" as follows:

Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation *must* be made available at the same site at which the service was rendered.

13.7.D(1) Required Documentation

The following are the requirements for the documentation of services rendered.

1. The date of the service.
2. The time spent providing the service. Time spent *must* be documented by one of the following methods:
   - Actual clock time of the start and actual clock time of the end of any period of uninterrupted one-on-one service to a single individual is documented. For example, if a personal care aide is providing services to one individual in a private home setting and devotes undivided attention to the care required by that individual, the actual clock time the aide began the services for that visit is the start time, and the actual clock time the aide finished the care for the visit is the stop time. (Example—Time spent: 9:30 a.m. to 10:30 a.m.) IF more than one visit per day is required, each separate visit has a start and a stop clock time noted. This method may also be used in a setting where the aide is providing care to and dividing his or her attention among several individuals. The actual clock start and stop time for each period of uninterrupted service for each individual is clearly documented.
   - When the personal care services are provided in congregate living settings, such as a Residential Care Facility I or II, when on-site supervision is available and personal care aide staff will divide their time among a number of individuals, the following *must* be documented: all tasks performed for each participant by date of service and by staff shifts during each 24 hour period.
   - Any other method that includes all required elements of documentation listed in this section.
3. A description of the service (specific tasks).

4. The name of the personal care aide who provided the service.
5. The participant's name and MO HealthNet number.
6. For each date of service: the signature of the participant, or the mark of the participant witnessed by at least one person, or the signature of another responsible person present in the participant's home or licensed Residential Care Facility I or II at the time of service. A responsible person may include the personal care aide's supervisor, if the supervisor is present in the home at the time of service delivery. The personal care aide may only sign on behalf of the participant when the participant is unable to sign and there is no other responsible person present. The entire signature of the participant or witness to the mark or the responsible party *must* be present in the record for each date of service billed to MO HealthNet. Initials are *not* acceptable in lieu of the entire signature. The participant's DCN is *not* required on the time sheet.

The provider should *not* submit claims solely on the basis of the prior authorization, but *must* base claims upon documentation of actual services rendered. The participant may have been in the hospital or nursing home during a month, may have been away from the home visiting family or friends, or there may have been other reasons why all services which were prior authorized were *not* necessary or could *not* be delivered. The prior authorization merely establishes the maximum number of hours and types of services which may be given to a participant during a time period. All units billed to MO HealthNet *must* be supported by the documentation of delivery as described in this section.

13.7.D(2) Unit of Service

A unit of personal care service is 15 minutes of direct service to the service participant, including time spent completing work vouchers and obtaining service participant signatures. Time spent for travel, lunch, breaks, or administrative activities such as completing other reports or paperwork shall *not* be included.

13.7.D(3) Accrued Units

Personal care providers may bill up to one full month of service on one detail line of a claim. It is permissible to accrue partial units of less than 15 minutes for several dates of service and bill the total, in whole units (15 minutes), at the end of the day, week, or month, as long as care delivery is consistent with the written plan of care.

The following instructions apply to billing accrued units on separate detail lines of a claim:

- When billing each date of service, partial units may be accrued and billed on the first date a whole unit is accrued. For example, a provider delivers care from 10:00 to 11:40 on June 1, then provides care from 10:00 to 12:10 on June 4. Six units of service are billed for June 1, and 9 units of service are billed on June 4.
- When billing multiple dates of service on one detail line of a claim, total the time spent in minutes for each date, divide by 15, and bill the number of whole units. Do *not* round up to the nearest whole unit. For example, at the end of the month, time spent in the provision of personal care to an individual in a congregate living facility, who received services every day, totals 620 minutes. 620/15=14.33 units. Bill for 14 whole units of service.
- When billing multiple dates of service on one detail line of a claim, dates during which the client is in a hospital, in a nursing home, visiting relatives or is ineligible should *not* be included in the range of dates.
- When billing multiple dates of service on one detail line of a claim, do *not* bill for dates of service falling in two separate calendar months.

13.8 THE AUTHORIZED NURSE VISIT

The authorized nurse visit is a covered service under the MO HealthNet Personal Care Program. Reimbursement is made for visits by a nurse to particular recipients with special needs, when such visits are prior authorized by the Department of Health and Senior Services' Division of Senior Services and Regulation or Bureau of Special Health Care Needs.

Providers of personal care services *must* have the capacity to provide these authorized nurse visits as well as the non-authorized nurse supervision requirements outlined in the Personal Care Program standards. The authorized nurse visit is in addition to the required nurse supervision of a monthly 10% sample of a provider's caseload. Any participant who receives the authorized nurse visit *must not* be included in the population of MO HealthNet recipients from which the 10% sample is drawn.

The nursing services that may be authorized in the participant's home are services of a maintenance or preventative nature provided to recipients with stable, chronic conditions. These services are *not* intended as treatment for an acute health condition and may *not* include services that are reimbursable as skilled nursing care under either the Medicare or MO HealthNet Home Health Programs. Should the personal care nurse detect a need for services that meet the definition of reimbursable skilled nursing care under the Home Health Program, the personal care nurse *must* alert

the participant's physician and the appropriate state agency. The physician may then refer the participant to a home health agency for treatment.

13.8.A PARTICIPANT ELIGIBILITY

To be eligible for the authorized nurse visit, the participant *must* have a documented need for the authorized nurse visit and have no adequate support system that could provide these services to the participant.

Authorized nurse visits are limited to 26 within a 6-month time frame.

13.8.B SERVICES WHICH MAY BE AUTHORIZED

The services of the nurse shall provide increased supervision to the personal care aide, assessment of the participant's health and the suitability of the care plan to meet the participant's needs. All advanced personal care recipients *must* have at least one authorized nurse visit per month. These services shall also include any referrals or follow-up action indicated by the nurse's assessment. In addition, these services *must* include one or more of the following where appropriate to the needs of the participant and authorized by the appropriate state agency:

- Filling a one-week supply of insulin syringes for a blind diabetic who can self-inject the medication but *cannot* fill his own syringe. This service includes monitoring the participant's continued ability to self-administer the insulin. If the participant is otherwise eligible for services reimbursed through the Home Health Program, the authorized nurse visit through the Personal Care Program to pre-fill the syringes is *not* appropriate, since the service could and would be provided by the home health nurse;
- Setting up oral medications in divided daily compartments for a participant who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;
- Monitoring a participant's skin condition when a participant is at risk of skin breakdown due to immobility or incontinence, or the participant has a chronic stage II decubitis ulcer requiring maintenance care and monitoring;
- Conducting health evaluations;
- Providing nail care for the diabetic participant or participant with circulatory or neurologic deficiency;
- Making a monthly on-site visit to each participant for whom advanced personal care services are authorized to evaluate the condition of the participant. A monthly visit report is made to the state agency case manager, via the provider communication

document, to report the participant's condition or other significant information concerning each advanced personal care participant; and

- Providing on-the-job training and competency testing for advanced personal care aides.

The state agency case manager, at their discretion, may recommend authorization of nurse visits in other situations.

The authorized nurse visits listed above may be provided by an LPN, if under the direction of an RN, except an RN *must* perform the on-the-job training and competency testing for advanced personal care aides.

The services provided during the authorized nurse visit shall *not* include any service which the client is eligible to receive under either the Medicare (Title XVIII) or MO HealthNet (Title XIX) Home Health Programs. The services listed above do *not* qualify, by themselves, for reimbursement under either program. However, should a client otherwise be eligible for home health services, then the following services: filling a one week supply of insulin syringes, setting up oral medications in divided daily compartments, monitoring a participant's skin condition when client is at risk of skin breakdown and nail care for a diabetic or client with other medically contraindicating conditions, will be provided by the home health agency.

It is the responsibility of the nurse to contact the participant's physician to obtain any necessary information or orders pertaining to the care of the participant. If the participant has an ongoing need for service activities that require more or less units than authorized, the nurse shall recommend in writing, that the plan of care be revised.

13.8.C AUTHORIZED NURSE ADMINISTRATIVE REQUIREMENTS

The following administrative requirements *must* be maintained whenever the authorized nurse services are delivered. These requirements are in addition to the administrative standards of the Personal Care Program outlined in Section 13.2.

The provider agency shall provide a general orientation for the nurse prior to the delivery of services which shall include instruction on the following:

- Code of ethics;
- Participant's bill of rights;
- Activities which shall or shall not be performed;
- Infection control and universal precaution procedures as defined by the Centers for Disease Control;

- Record keeping requirements and reporting forms required by the personal care provider or state agency who authorized the service;
- Occupational Safety Hazards Administration standards regarding precautions to be taken to avoid risks associated with bloodborne pathogens; and
- Communicating with appropriate state agency and taking appropriate action on clinical changes in the participant's condition.

13.8.D AUTHORIZED NURSE VISIT RECORDS

Written notes concerning the authorized nurse's visits *must* be maintained in the participant's file. In addition, notes of any verbal communication and copies of any written communications with the participant's physician, other health care professional, or state agency case manager, concerning the care of that participant, is also maintained in the participant's file.

13.9 ADVANCED PERSONAL CARE SERVICES

The provision of advanced personal care services is an option available to providers under the MO HealthNet Personal Care Program. These advanced personal care tasks are maintenance services provided to assist a participant with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body functions.

Advanced personal care is a maintenance service and should never be used as a therapeutic treatment. Recipients who develop medical complications requiring skilled nursing services while receiving advanced personal care services should be referred to their attending physician who may, if appropriate, order home health services, inpatient care, or institutionalization.

All personal care standards set forth in Section 13 also apply to the Advanced Personal Care Program unless specifically stated otherwise. The requirements contained in this section are in addition to the Personal Care Program standards and pertain only to the delivery of advanced personal care services.

13.9.A SERVICE DESCRIPTION

Examples of advanced personal care services that may be performed are:

- Routine personal care for persons with ostomies (including tracheostomies, gastrostomies and colostomies with well-healed stoma) and external, indwelling, and suprapubic catheters. This care includes changing bags, and soap and water hygiene around ostomy or catheter site;
- Remove external catheters, inspect skin and reapplication of same;

- Administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (pre-packaged only) for recipients without contraindicating rectal or intestinal conditions;
- Apply medicated (prescription) lotions or ointments, and dry, non-sterile dressing to unbroken skin;
- Use lift for transfers;
- Manually assist with oral medications which are set up by a registered or licensed practical nurse;
- Provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology; and
- Apply non-sterile dressings to superficial skin breaks or abrasions as directed by a registered or licensed practical nurse.

Personal care providers choosing to offer advanced personal care are required to provide all of the above listed services.

13.9.B PROVIDER PARTICIPATION REQUIREMENTS

Providers choosing to deliver advanced personal care services *must* have a valid MO HealthNet Personal Care Provider Agreement in effect with the Division of Medical Services (Section 13.1.D). In addition, the provider *must* sign an addendum to their Title XIX Personal Care Provider Agreement, indicating their agreement to provide advanced personal care services.

Only those personal care providers meeting one of the following requirements may sign the addendum; and subsequently, be authorized to provide advanced personal care:

A. Title XX (Social Service Block Grant) providers whose contract includes advanced personal care.

B. A Residential Care Facility I or II licensed and approved by the Division of Senior Services and Regulation.

   Upon approval of the advanced personal care provider application, RCF advanced personal care providers may only furnish advanced personal care services to recipients in their RCF. If an RCF provider wants to provide advanced personal care services in the community, they *must* contact the Division of Senior Services and Regulation and *must* receive approval as a Title XX (Social Service Block Grant) provider before services can be approved. Providers may contact the Division of

Senior Services and Regulation, Bureau of Quality Assurance at (573) 751-3082 for information regarding the SSBG provider program.

The addendum and verification of the Title XX contract should be submitted to the MO HealthNet Division, Provider Enrollment Unit, P.O. Box 6500, Jefferson City, Missouri 65102-6500. Click here for a copy of the MO HealthNet Advanced Personal Care Program Addendum to Title XIX Participation Agreement for Personal Care Services.

13.9.C PARTICIPANTS MINIMUM NEEDS CRITERIA

In addition to meeting the eligibility requirements of the Personal Care Program (Section 13.1.E), the participant *must* have a documented need for the advanced personal care service(s) and have no adequate support system that could provide these services to the participant. The participant *must* have a qualifying altered body function, etc. as described in Section 13.9. Recipients are assessed as eligible for personal care or advanced personal care by one of the appropriate state agencies, the Department of Health and Senior Services' Division of Senior Services and Regulation, the Bureau of Special Health Care Needs, or Prevention and Care Programs. (For children and for persons with AIDS/HIV, see Section 13.10.G and Section 13.11.)

13.9.D AUTHORIZATION OF ADVANCED PERSONAL CARE

All units of advanced personal care *must* be authorized by the state agency staff before services can be delivered. The plan of care *must* be developed, reviewed, and updated by an RN in cooperation with state agency staff and *must* be approved by the participant's physician on at least an annual basis.

The plan of care *must* include the following items:

- Identification of the specific advanced personal care tasks to be provided;
- Other activities permitted;
- Frequency of services and on what days those services are generally provided;
- Functional limitations of the participant;
- Nutritional requirements if a special diet is necessary;
- Medications and treatments as appropriate;
- Any safety measures necessary to protect against injury; and
- Any other appropriate items.

13.9.E ADVANCED PERSONAL CARE RN SUPERVISION

RN supervision is essential to the safe provision of advanced personal care services. Certain nurse functions for advanced personal care recipients may be performed by a licensed practical nurse; others *must* be performed by a registered nurse. The following outlines the nursing requirements for advanced personal care recipients:

The registered nurse *must*:

- conduct an initial assessment visit and develop the plan of care for recipients with advanced personal care needs, in collaboration with the state agency staff. This visit may be authorized and billed to MO HealthNet as an authorized nurse visit.
- conduct on-site visits to all advanced personal care recipients at intervals no greater than six months. During the visit, the RN *must* conduct and contemporaneously record and certify by his/her signature an individualized evaluation of the participant's condition and the adequacy of the authorized services to meet the needs and conditions of the participant.
- be available, at least by telephone, during any period of time advanced personal care is being provided.
- observe the successful execution by the aide of each advanced personal care task during an on-the-job training session, and certify the successful completion of the task in the aide's personnel record. This visit may be authorized and reimbursed.

The licensed practical nurse may:

- conduct the monthly authorized nurse visit to evaluate the condition of the advanced personal care participant, and send monthly visit reports to the state case manager via the Provider Communication form.

13.9.F ADVANCED PERSONAL CARE AIDE REQUIREMENTS

In addition to meeting the basic personal care aide requirements discussed in Section 13.3.B of this manual, all advanced personal care aides employed by the provider *must*:

- be an LPN or a certified nurse assistant;
- be a competency evaluated home health aide having completed both written demonstration portions of the test required by the Missouri Department of Health and Senior Services and 42 CFR 484.36; or
- have successfully worked for the provider for a minimum of three consecutive months while working at least fifteen hours per week as an in-home aide that has received personal care training.

13.9.G ADVANCED PERSONAL CARE AIDE TRAINING

Advanced personal care aides *must* receive eight classroom hours of advanced personal care training in addition to the required basic training for personal care aides as described in this manual. The provider shall have written plans of the classroom training; such training *must* include at a minimum the following topics:

- observation of the participant and reporting observations;
- application of ointments/lotions to broken skin;
- manual assistance with oral medications;
- prevention of decubiti;
- enemas;
- basic personal care for persons with ostomies and catheters;
- proper cleaning of catheter bags;
- bowel routines (rectal suppositories, spinchter stimulation);
- range of motion exercises;
- use of lifts for transfers;
- positioning and support of the participant;
- applying non-sterile dressings to superficial skin breaks; and
- universal precaution procedures as defined by the Centers for Disease Control.

The provider *must* document the dates and hours of the eight classroom hours of advanced personal care training received by the personal care aide in the aide's personnel file.

13.9.G(1) Waiver of Classroom Hours

The provider may waive the eight classroom hours of advanced personal care training if the following conditions are met:

- the advanced personal care aide is a certified nurse aide or a licensed practical nurse; or
- the personal care aide has previously completed advanced personal care training from a MO HealthNet or SSBG in-home provider agency; and
- the personal care aide has been employed at least half time by a MO HealthNet or SSBG in-home provider agency *as an advanced personal care aide within the prior six months.*

If the waiver of advanced personal care training has been granted, documentation that the above conditions have been met *must* be placed in the aide's personnel record and available for inspection.

13.9.G(2) Demonstration of Competency

Prior to performing any advanced personal care task for any participant for the first time, the advanced personal care aide who is *not* a licensed nurse *must* demonstrate competency, specifically for the advanced personal care tasks as they appear on the participant's plan of care. This competency *must* be demonstrated in an on-the-job training session conducted by the registered nurse. The registered nurse *must* document the aide's competency in performing each task in the aide's personnel file. The required demonstration of each advanced personal care task during an on-the-job training session with an RN may *not* be waived. RN visits necessary for task observation and certification in the home may be prior authorized and billed to MO HealthNet as an authorized nurse visit. RN task observation and certification in a laboratory, or other non-home setting, may *not* be billed.

The RN *must* observe the aide performing the following tasks in the participant's home.

- routine personal care of persons with ostomies (including tracheostomies, gastrostomies, colostomies all with well-healed stoma) which includes changing bags, and soap and water hygiene around ostomy site;
- personal care of persons with external, indwelling and suprapubic catheters which includes changing bags, and soap and water hygiene around site;
- removal of external catheters, inspect skin and reapply catheter;
- administration of prescribed bowel programs, including use of suppositories and sphincter stimulation per protocol and enemas (prepackaged only) for recipients without contraindicating rectal or intestinal conditions;
- use of assistive device for transfers.

The RN may observe the following tasks in the home or lab setting.

- application of medicated (prescription) lotions, ointments or dry, aseptic dressings to unbroken skin including stage I decubitus;
- application of aseptic dressings to superficial skin breaks or abrasions as directed by a licensed nurse;
- manual assistance with noninjectable medications as set up by a licensed nurse;

- passive range of motion (nonresistive flexion of joint with normal range) delivered in accordance with the care plan.

13.9.G(3) Annual In-Service Training

Advanced personal care aides *must* also receive ten hours of annual in-service training, the same as any personal care aide (see In-Service Training 13.6.E).

13.9.H ADVANCED PERSONAL CARE RECORDS

Providers participating in the delivery of advanced personal care services *must* maintain all records and documentation required of the MO HealthNet Personal Care Program. In addition, the following records and documentation that pertain only to the delivery of advanced personal care services *must* be maintained by participating providers.

13.9.H(1) Aide's Personnel Record

The personal care aide's personnel record shall contain:

- Documentation of the eight classroom hours of advanced personal care training including dates and topics;
- Documentation for any waiver of the eight classroom hours of advanced personal care training; and
- Signed statement(s) by the RN certifying that the personal care aide has successfully completed on-the-job training for each advanced personal care task the aide is required to perform.

13.9.H(2) Participant's Record

The case record of any participant receiving advanced personal care services shall include:

- Written notes concerning any authorized nurse visits including the six month supervisory visit and the monthly nurse visit report. In addition, notes of any verbal communication and copies of any written communication with the participant's physician or other health care professional, concerning the participant's care *must* be maintained in the participant's case record.
- A closing summary documenting that 21 day notification was given to the state agency case manager and the advanced personal care participant prior to the date of closing, the participant's authorization date, the most recent care plan including identified functional disabilities, the reason for closing, the date of closing, and a follow-up plan, if applicable.

13.10 PERSONAL CARE SERVICES FOR CHILDREN THROUGH THE HEALTHY CHILDREN AND YOUTH PROGRAM

The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) mandated expanded services to children through the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT). In summary, OBRA '89 requires states to provide medically necessary treatment for children for conditions or problems identified through the EPSDT health screen, even if the needed medical service is beyond the scope of the state's MO HealthNet state plan. While personal care is a service under the State Plan in Missouri, historically the service has been utilized by few children. Children with serious home care medical needs were served through the Children's Waiver prior to OBRA '89, which included private duty nursing, home health, therapy, supplies, and aide service.

Missouri implemented the mandates of OBRA '89 through the Healthy Children and Youth (HCY) Program. Many of the services now available to children under the HCY Program are prior authorized by the Bureau of Special Health Care Needs of the Department of Health and Senior Services.

13.10.A SERVICE AUTHORIZATION

Personal care services for MO HealthNet eligible children (aged 20 and under) may be authorized by the Bureau of Special Health Care Needs. There are major differences in services for children and services for adults. In cases of personal care for a child, the provider agency may receive a referral directly from a family, hospital, physician, or other referral source. The provider may then request approval for prior authorization from the Bureau. This is different from personal care for an adult. In those cases, a state agency case manager receives the referral first, then assesses the participant's eligibility for the service, then notifies the agency of the authorization and care plan.

Children are determined to be in need of personal care by medical necessity, rather than by being assessed to have nursing home level of care needs. An example of a personal care need for a child is one who needs total personal care, or requires extra assistance in bathing, toileting, eating, or other activities of daily living, because of a medical condition. The fact that a child has a caretaker does *not* make the child ineligible for personal care.

Reimbursement for personal care services delivered to children enrolled in MO HealthNet's Managed Care Program are the responsibility of the health plan in which the children are enrolled. Charges for services provided to MO HealthNet Managed Care enrolled children may *not* be billed to MO HealthNet. Health plans participating in the MO HealthNet Managed Care program are responsible for arranging, authorizing and reimbursing for all personal care delivered to enrollees. For more information about MO HealthNet's Mangaed Care program, please reference Section 12.6 and 13.12.B(1).

13.10.B MEDICAL CRITERIA

The following is a list of examples of medical problems that meet the criteria for medical necessity for personal care services for children. This list is *not* exhaustive and only provides a guideline of conditions.

Children who:

- have poorly controlled seizures, other than severe generalized tonic/clonic (grand mal) seizures;
- require assistance with orthotic bracing, body casts, or casts involving one full limb or more. (A typical short or long arm cast on an otherwise healthy child does *not* necessitate services of a personal care aide);
- are incontinent of bowel and/or bladder after age three. (Chronic bedwetting and encopresis are excluded);
- have persistent and/or chronic diarrhea, regardless of age;
- have significant central nervous system damage affecting motor control;
- have organically based feeding problems; or
- require assistance with activities of daily living. This applies to children unable to perform *age appropriate* functions of bathing, maintaining a dry bed and clothing, toileting, dressing, and feeding. Children with a diagnosis of developmental delay or mental retardation may be eligible for personal care; if their ability to perform age appropriate personal care is impaired.

The following are examples of cases where personal care services are *not* appropriate for a child:

- Cases that require skilled nursing services. These services are available through the Home Health and the Private Duty Nursing Programs.
- Personal care for any child when there is no documented medical need for the care. For example, personal care for a healthy infant or toddler with no medical problems is inappropriate, as parents or other caregivers are expected to meet those needs as a normal function of parenting. However, when a child's personal care needs are greater than those of a healthy child of the same age, because of a medical condition or disability, then personal care may be appropriate to assist the caregiver in meeting those additional needs.
- Respite or baby-sitting service. Personal care services *must* include the performance of direct hands-on assistance and *cannot* consist solely of oversight or supervision. If a parent *must* be gone from the home when the personal care is needed, a personal care

aide may deliver the service while the parent is absent, as long as the child has a medical need for the service.

- Homemaker-only service. While some homemaking service is appropriate through the Personal Care Program, such as changing bed linens or meal preparation and clean-up, homemaker services should represent only a small portion of the Personal Care Plan for Children. A parent or caretaker who is unable to perform the homemaking tasks because of their own disability may be referred to the Division of Senior Services and Regulation for assessment. In these cases, both the parent and child may be authorized for personal care services.

13.10.C EXAMPLE CASES

The following describe cases where personal care is appropriate. These examples are *not* all inclusive, and are *not* intended to describe the only situations in which personal care for children may be authorized. These case descriptions are meant to be used as a guide for providers to use in deciding whether or not to accept a referral and to request prior authorization.

- A 13-year-old child who uses a wheel-chair, and needs assistance with breakfast and getting ready for school. The parent *must* leave for work at 6:30 in the morning, too early to get the child ready for the bus. The child is of an age appropriate to get his own breakfast and get dressed for school. Personal care is appropriate for this child with disabilities and with a care plan specific to his needs.
- A 15-year-old child with disability who weighs 150 lbs. needs personal care. The parent is at home, and is available to provide the care; however, the child is too large for the parent to manage safely alone. Personal care is appropriate in this case.
- A parent has four children, ages 5 and under. The 5-year-old child needs personal care due to a medical condition. The other three children have no medical problems. If the child were an only child, personal care is questionable, in spite of the disability, because of the availability of the parent. However, the needs of the 3 additional children render the parent unavailable to meet the extra personal care needs of the child with disabilities.
- An emancipated young adult under 21, with personal care needs following surgery or an injury.

13.10.D FAMILY AS CAREGIVERS

- The availability of the parent should be considered when developing a care plan, but should *not* be a reason why personal care is denied. The care plan should describe in detail why the parent is unable to provide personal care themselves, or why they need assistance.
- A parent's or other caregiver's outright refusal to accept some responsibility for the care of a child should be reported to the Child Abuse/Neglect hotline. The personal care plan *must* be implemented with some assistance and cooperation of the normal caregiver.
- The aide employed by the agency who actually delivers the personal care service *must not* be a family or household member.

13.10.E CARE PLAN DEVELOPMENT AND RN SERVICE

The initial Personal Care Plan for Children *must* be developed by an RN, unless the child is a client of the Department of Mental Health and has an Individual Habilitation Plan (IHP) which contains sufficient documentation of the need for personal care and the extent of the service required (see Section 13.10.F for "Department of Mental Health clients"). The agency may bill MO HealthNet separately for the initial evaluation and care plan development, when a face-to-face evaluation of the child is conducted. An evaluation procedure code, which does *not* require prior authorization, may be billed twice per year, per agency, per child. The RN evaluation is reimbursed at the same rate as the prior authorized nurse visit in the Personal Care Program designed for the adult population. The RN assesses and evaluates the child, develops the care plan, and obtains the physician's approval. The care plan and the physician's approval *must* be submitted to the Bureau of Special Health Care Needs with the Prior Authorization Request. (See Section 14 for details.)

Based on the care plan developed by the RN or established in the IHP, the personal care provider submits a request for approval for a specific number of hours of personal care service to be delivered to the child. The personal care plan should specify the number of hours per day, the frequency they will be delivered, the duration of service (how many weeks or months) and the specific tasks the aide is expected to perform. Personal care is authorized in one-month increments for up to 6 months per Prior Authorization Request.

The provider may request prior authorization for additional nurse visits, on a weekly basis, if the care plan indicates the child's condition may change and should be reassessed frequently. The authorized nurse visit may be used also for extra supervision of the aide. For example, in the case of a child with chronic diarrhea, nurse visits may be necessary to reassess the care plan frequently, as well as to monitor the child's skin condition.

The personal care provider may request prior authorization for RN visits to evaluate the child prior to requesting reauthorization, if this *must* be done more often than twice per year. If assessment is required twice per year or less, it should be billed via the nurse evaluation procedure code, which does *not* require prior authorization.

The authorized nurse visit in the Personal Care Program should *not* be confused with the services available through the Home Health Program. Cases in which the nurse is needed for skilled treatment of acute conditions should be authorized for the skilled nurse visit in the Home Health Program or the Private Duty Nurse Program.

13.10.F DEPARTMENT OF MENTAL HEALTH CLIENTS

Many MO HealthNet-eligible children may also be clients of the Department of Mental Health. In these cases, the Department of Mental Health's case manager for the child may assist the provider in developing a plan of care. Children who are DMH clients may have an Individual Habilitation Plan (IHP), which is developed by a team of professionals including a physician. The IHP may be instrumental in providing the basis for the plan of care. The physician's signature on the IHP may serve as certification for personal care services, if personal care needs are specifically addressed in the IHP. Even when the IHP is used in conjunction with the Prior Authorization Request, the services requested may *not* extend past one year beyond the date of the physician's signature.

If the IHP contains sufficient information for the personal care provider agency to develop the plan of care, the RN evaluation/assessment visit is *not* necessary and may *not* be billed.

Example: Johnny Smith's IHP was completed and the physician's signature is dated September 30, 1995. His IHP specifies the need for personal care services. The personal care provider is requesting prior authorization to begin services August 1, 1996. While personal care may be authorized for up to six months at a time, in this case the services may only be approved through September 30, 1996. Services beyond September 30, 1996, require a new physician's certification, either on a new IHP, the Prior Authorization Request form or other document on which the physician orders personal care.

13.10.G ADVANCED PERSONAL CARE SERVICES FOR CHILDREN

Children who require devices and procedures relating to altered body functions may be eligible for advanced personal care services. The provider agency may request prior authorization from the Bureau of Special Health Care Needs. Advanced personal care services for children *must* be delivered in accordance with the training and supervisory requirements for advanced personal care, as described in Section 13.9 of this manual.

In developing the care plan that includes advanced personal care, the provider *must* be specific about the length of time that is required each day for advanced personal care. Only the times designated specifically as advanced personal care may be reimbursed at the higher rate. All other time *must* be authorized and reimbursed at the basic personal care rate.

13.10.H PHYSICAL DISABILITIES WAIVER PROGRAM

The Physical Disabilities Waiver Program was designed to provide home and community-based services to individuals who have reached the age of 21 and are no longer eligible for services through the HCY Program. Private duty nursing, specialized medical equipment/supplies, and waiver attendant care services may be authorized through this waiver. Services for the Physical Disabilities Waiver Program require prior authorization by the Bureau of Special Health Care Needs.

13.11 PERSONAL CARE SERVICE DELIVERY FOR PERSONS WITH AIDS

This section addresses the case management of State Plan Personal Care services for persons with AIDS and HIV-related illnesses. A brief overview of the services available under the AIDS Waiver Program is included.

All MO HealthNet-enrolled personal care providers are eligible to provide AIDS waiver personal care. Providers may wish to contact the Department of Health and Senior Services, Section for Communicable Disease Prevention, Prevention and Care Programs in their area to indicate interest in receiving referrals for AIDS waiver attendant care. For more information on the AIDS Waiver Program, please reference Section 13 of the AIDS Waiver Manual.

13.11.A GENERAL INFORMATION

The AIDS Waiver Program provides home and community based treatment as a cost effective alternative to the institutional care for individuals with AIDS. The AIDS Waiver Program is jointly administered by the Department of Health and Senior Services (DHSS) and the Department of Social Services/MO HealthNet Division (DSS/MHD). The three services provided under this waiver include private duty nursing, attendant care, and supplies.

- Private-duty nursing is defined as extended skilled nursing care provided in the participant's home by RNs and LPNs. The home visits are greater than three hours per day in a 24-hour period and are based on written orders from the physician. Private duty nursing is provided by MO HealthNet enrolled home health and private duty nursing agencies who sign an addendum to their Title XIX provider agreement.

- Personal care is defined as the provision of assistance with activities of daily living such as bathing, grooming, dressing, housekeeping, laundry, and meal preparation in the participant's home. Housecleaning and laundry may *not* constitute more than one third of the time spent in the home and *must* be related to the medical needs of the participant. This service may be provided by agencies who are enrolled MO HealthNet providers of State Plan personal care.

The personal care services provided under the waiver are in excess of the benefit available under the State Plan Personal Care Program. The maximum Title XIX monthly spending cap for State Plan Personal Care services *must* be met by the participant prior to receiving personal care services under the waiver.

- Supplies include underpads, adult diapers, and non-sterile gloves. No other supplies are included. These supplies are *not* available in the home under the state plan personal care programs. They are provided by MO HealthNet enrolled DME providers or home health agencies. Department of Health and Senior Services coordination staff manually prices these supplies.

13.11.B HIV SERVICE COORDINATION PROGRAM

The AIDS waiver is one part of the statewide system of HIV Care Coordination operated by the Department of Health and Senior Services (DHSS). The program provides assistance in locating and coordinating services for HIV-infected people. Service coordination is provided free of charge regardless of the participant's income or insurance status.

Recipients receive service coordination throughout their illness, starting if needed, at the time of the diagnosis of HIV infection. The DHSS contracts for case management of all HIV-infected persons, but only Title XIX eligible persons may access the waivered services and/or State Plan Personal Care.

13.11.C CASE MANAGEMENT OF STATE PLAN PERSONAL CARE SERVICES

In accordance with an inter-agency agreement between the Department of Health and Senior Services and Department of Social Services/MO HealthNet Division, the HIV Service Coordination System has been designed to provide case management services for HIV-infected persons receiving, or eligible to receive, state plan personal care services.

The DHSS and its contract service coordination staff's case management of state plan personal care services parallels the existing system and functions by the other state agency case managers. These services include assessment and evaluation, development of the plan of care and prior authorization of services. The types of forms used and the coordination between provider and state case manager is functionally the same.

State plan personal care service delivery under the case management of the HIV Care Coordination System is subject to all policies and standards applicable to the Personal Care Program.

In order to be evaluated for HIV Service Coordination services, recipients should be referred to the Service Coordination office in their area. They may be self-referred or referred by health care professionals, volunteer agencies, or relatives. The HIV Services Coordination Regions and regional office telephone numbers are outlined in Section 14 of this manual.

13.11.D INFECTION CONTROL GUIDELINES

While it is recommended that in-home care providers practice universal precautions in the delivery of all personal care services, the policies and procedures related to infection control are essential to the care of persons with AIDS.

The following infection control guidelines have been developed for the person with AIDS at home and for their caregivers. These guidelines were developed by Lusby and Schietinger and are based upon the Centers for Disease Control (CDC) recommendations and epidemiological data.

13.11.D(1) Handwashing

Handwashing is the single most important way to prevent the spread of an infectious organism. Soap and water should be used at all times. Handwashing should be done before and after all aspects of participant care, including preparation and serving of meals to recipients in their homes. If running water is *not* available, gloves should be worn. Handwashing is advised after removing and disposing of gloves.

13.11.D(2) Gloves/Protective Smock

Gloves serve to block the transmission of any infectious agent to a potential host. The caregiver should wear gloves in the following situations:

- When caring for open skin lesions or wounds.
- When handling secretions or excretions such as emesis, urine, stool, blood, or wound secretions.
- When handling soiled diapers, incontinence pads, linens, or clothing.
- When providing oral care if contact with oral lesions or blood is likely.
- When providing perineal care to the person who is incontinent or to a woman who is menstruating or who has postpartum bleeding.

Gloves are *not* required when bathing AIDS recipients without skin lesions, when assisting AIDS recipients with transfers or ambulation, when feeding AIDS recipients, or when talking with or counseling an AIDS participant.

Protective smocks are *not* required for routine care giving but aprons or gowns may be used if soiling of the caregiver or his/her clothing is likely.

13.11.D(3) Handling of Needles and Other Sharp Instruments

Needles, scalpels, and other sharp instruments *must* be handled with particular caution because the virus is capable of being transmitted through blood contact. Needles should *not* be recapped or resheathed after use but disposed of intact in a puncture-resistant container. These containers may be available through supply companies. Household metal tins or heavy plastic bottles may be substituted. The containers *must* be leak proof and have a properly fitting lid that will *not* come open when transported during trash removal. The container should be discarded and replaced when it is three-fourths filled to prevent injury.

13.11.D(4) Disposal of Supplies

Soiled disposable supplies used in the care of the person with AIDS (gloves, diapers, incontinence pads, toilet paper, dressing supplies, respiratory therapy tubing, or nebulizers) may be placed in a heavy-duty plastic bag that can be securely fastened at the top. If a heavy-duty bag is *not* available, double bagging should be done. Removal of these plastic bags, as well as the sharp containers, should be in conformity with local solid waste disposal regulations used by the community. Usually this is the regular trash disposal system. The provider's local public health department should be aware of these regulations and be able to assist in the interpretation and implementation.

13.11.D(5) Environmental Safety

Environmental safety is maintained by usual household cleaning methods. Standard household detergents are appropriate to maintain a safe environment for the person with AIDS and other members of the household.

For floor or counter surfaces soiled by secretions or excretions, removal of surface debris and cleansing with hot, soapy water followed by disinfecting with a 10 percent bleach solution (1 part bleach, 9 parts water) is adequate. The bleach solution also can be used to disinfect the toilet, tub, and shower after routine cleaning. Bedpans and commodes should be cleaned regularly with household detergents and hot water. Soiled linens or clothing may be laundered in the

household or laundromat washing machine. One cup of bleach along with the regular detergent should be added to water prior to placing clothes in the washer.

Items that are shared with other recipients, such as toilets, showers, or bedpans, do *not* require different handling or cleansing. The cleaning procedures described earlier are sufficient. The procedures should be administered between recipients if a participant is incontinent, has diarrhea, or has open genital lesions.

Dishes can be cleaned with those of other household members using hot soapy water. Utensils do *not* need to be isolated.

Weekly cleaning of the interior surface of the refrigerator as well as the bathroom fixtures help control the growth of molds or fungi. Routine household cleaning agents can be used.

13.11.D(6) Pets

Pets may pose a particular threat to the person with AIDS. Organisms sometimes present in the excrement of cats, birds, and fish may cause serious illness because the immune system of the person is compromised. For recipients who wish to keep pets, someone other than the person with AIDS should be responsible for cleaning the bird cage, cat litter box, or fish tank.

13.11.D(7) Pregnant Caregivers and AIDS

Women who are pregnant or who may be pregnant should be aware that persons with AIDS are prone to two viruses—cytomegalovirus and herpes virus—which have been known to cause serious birth defects and/or miscarriages. Infection control guidelines discussed earlier prevent caregivers from acquiring HIV infections.

13.11.D(8) Durable Medical Equipment and AIDS

The management and cleaning of durable medical equipment (DME) is an issue of particular concern for home health care providers caring for persons with AIDS. The CDC has issued no specific guidelines for the provision or cleaning of DME used in the home of a person with AIDS. However, the CDC has recommended the use of a ten percent bleach solution to wipe down soiled DME that *cannot* be sterilized by ethyl oxide or autoclaved. Most DME used at home for recipients with AIDS (hospital beds, commodes, walkers, wheelchairs) *cannot* be autoclaved or sterilized.

The HIV Service Coordination Program provides special education for direct care staff in understanding infection control and in dispelling fear and misinformation about AIDS. Providers may contact their HIV Care Coordination regional office for further information.

13.11.D(9) Confidentiality

According to state law, health care personnel working directly with HIV-infected individuals have a need to know this information for the purpose of providing direct patient health care.

It is the responsibility of the HIV-infected individual to disclose this information to any provider of health care when such person receives health care services. This notification should be made prior to receiving services from the health care professional.

Personal care providers serving an HIV-infected individual *must* disclose this information to employees providing direct health care services to the individual. Such disclosure should be done in strictest confidentiality and prohibit further disclosure.

Medical records of HIV-infected individuals shall be afforded the same confidentiality protection afforded other medical records.

No civil liability shall accrue to any health care provider as a result of making a good faith report to the Department of Health and Senior Services about a person reasonably believed to be infected with HIV.

13.12 MANAGED CARE

13.12.A PRIOR CONTENTS NO LONGER APPLICABLE

13.12.B MANAGED CARE—MO HEALTHNET MANAGED CARE

Personal care and advanced personal care services are covered through the MO HealthNet Managed Care program for recipients in certain MO HealthNet Managed Care regions. The participant's inclusion or exclusion from participation in one of the MO HealthNet Managed Care plans may be verified by contacting the interactive voice response system at (573) 635-8908 or through a point of service terminal.

13.12.B(1) Health Plan

All services covered by the health plans are billed to and paid by the plan. The health plan provider name and phone number is identified while verifying participant eligibility. The health plan provider *must* be contacted for approval prior to delivering services.

Services to be provided to a participant on or after the effective date of enrollment in a managed health care plan which were authorized by the state prior to the participant's enrollment with a health plan *must* be approved by the health plan.

13.13 PARTICIPANT NONLIABILITY

MO HealthNet covered services rendered to an eligible participant are *not* billable to the participant if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

13.14 PERSONAL CARE SERVICES AND THE HOSPICE PROGRAM

MO HealthNet covers hospice services for MO HealthNet eligible persons with a terminal condition whose life expectancy is six months or less. The Hospice Program provides palliative care, rather than active treatment. The Hospice Program includes the following services:

- Nursing care provided by or under the supervision of a registered nurse;
- Medical social services;
- Physician services performed by a doctor of medicine or osteopathy to meet the general medical needs of the participant to the extent that these needs are *not* met by the attending physician;
- Counseling services *must* be available to both the participant and the family members or other persons caring for the participant at home. Counseling, including dietary counseling, may be provided both for the purpose of training the participant's family member or other caregiver to provide care and for the purpose of helping the participant and those caring for him/her to adjust to the participant's approaching death; bereavement and spiritual counseling;
- All drugs (prescription or over the counter) and biologicals used primarily for pain or symptom control of the terminal illness;
- Short term inpatient care required for pain control or acute or chronic symptom management;

- Short term inpatient respite care (if provided in a nursing facility (NF), the NF *must* have 24-hour RN coverage);
- Medical appliances and supplies related to the participant's terminal illness. This includes covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the participant's terminal illness. Medical supplies include those that are part of the written plan of care;
- Room and board in a MO HealthNet-certified nursing facility;
- Home health aide and homemaker services. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the participant such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the participant. Aide services *must* be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care; and
- Physical therapy, occupational therapy, and speech-language services for purposes of symptom control or to enable the participant to maintain activities of daily living and basic functional skills. Hospice recipients are "locked in" to the hospice provider and *must* receive all of their medical care related to their terminal illness through the hospice provider with a few exceptions. Personal care and home and community based waiver services are among the exceptions.

When personal care services are required which are beyond the scope of the home health aide and homemaker services covered under the hospice benefit, the state agency case manager may authorize additional services to be provided by a personal care provider. The state case manager *must* work closely with the hospice provider to develop a personal care service authorization that does *not* duplicate, but augments, the aide services the hospice *must* provide.

When authorizing personal care services for a participant who has elected hospice, the case manager should indicate that a hospice is also providing care and who the hospice provider is.

If it is discovered while serving a participant that a hospice provider is also involved and if the referral information does *not* indicate that the state case manager is aware of the hospice election, please notify the case manager. Hospice recipients are identified while verifying participant eligibility on the interactive voice response system or the point of service terminal.

END OF SECTION

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