



Personal Care Manual

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Introduction

The Missouri Title XIX (Medicaid) State Plan Personal Care Program offers medically related services designed to meet the maintenance needs of participants with a chronic, stable condition. State Plan Personal Care services are provided through one (1) of two (2) models, agency model and consumer-directed services (CDS) model. Agency model personal care services are provided in accordance with Code of State Regulations (CSR), [13 CSR 70-91.010](#) and [19 CSR 15-7](#), and CDS model personal care services are provided in accordance with [19 CSR 15-8](#).

Available personal care services include agency model basic personal care and advanced personal care (APC), CDS model personal care, and authorized nurse visits.

Section 1: Reimbursement Methodology

Reimbursement for personal care services is made on a Fee-For-Service (FFS) basis. The maximum allowable fee for a unit of service has been determined by the MO HealthNet Division (MHD) to be a reasonable fee, consistent with efficiency, economy and quality of care. Payment for covered services is the lower of the provider's actual billed charge or the maximum allowable per unit of service.

A unit of personal care service (under either model) is 15 minutes of direct service to the participant, including time spent documenting services provided. Refer to [Section 4.3](#) of this manual for more information on a unit of service.

1.1 Fee Schedule

Under a fee schedule, each procedure, service, medical supply, and equipment covered under a specific program has a maximum allowable fee established. MHD determines a maximum allowable fee for the services based upon the current appropriated funds.

The [Fee Schedule](#) identifies covered and non-covered procedure codes, restrictions, allowed units, and the MHD allowable fee per unit. The Fee Schedule is updated monthly and is intended as a reference, not a guarantee for payment.

The [Fee Schedule](#) allows for the downloading of individual files or the search for a specific procedure code. Some procedure codes may be billed by multiple provider types. Categories within the Fee Schedule are set up by the service rendered and are not necessarily provider specific.

Refer to [Section 2](#) of this manual for program-specific benefits and limitations.

Section 2: Benefits and Limitations

2.1 Personal Care Program General Information

Service Definition

Personal care services, regardless of the model by which the services are delivered, are medically-oriented tasks provided in the participant's home in accordance with a care plan approved by the

State or a care plan reviewed and approved by a physician as the home care necessary to meet a participant's physical needs. This enables the participant to remain in their 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 participant group (e.g., aged, children) for whom the personal care services are being authorized.

For purposes of the Personal Care Program, the term 'home' includes participants residing in Residential Care Facilities (RCFs) or Assisted Living Facilities (ALFs). 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.

A care plan is developed in collaboration with the participant, who will provide a signature of agreement. The care plan includes an identification of the services and tasks to be provided, frequency of services, and the maximum number of units of service for which the participant is eligible per month.

Agency model 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. CDS model personal care services may be provided by a member of the participant's family but may not be a legally responsible individual (e.g. spouse, guardian). A family member is defined as a spouse; parent; sibling; child by blood, adoption, or marriage (stepchild); grandparent; or grandchild.

Agency Model Personal Care Tasks

Agency model basic personal care services assist with hands-on tasks that assist a participant with everyday activities that they are unable to perform on their own. Examples of basic personal care service tasks that may be performed are assistance with:

- Dietary needs, including meal preparation, eating/feeding, and meal cleanup
- Dressing and grooming, including helping with dressing and undressing
- Toileting and incontinence, including assisting with transferring to/from the toilet, commode, bedpan, urinal, cleansing after use, and assisting with incontinence episodes
- Making beds
- Changing linens
- Brushing, combing, and shampooing hair
- Bathing/showering, including bed baths
- Oral hygiene, such as brushing teeth and denture care

- Nail care, such as cleaning and cutting fingernails and toenails (for participants without contraindicating conditions)
- Shaving with an electric or safety razor (electric razors for participants with diabetes or contraindicating conditions)
- Mobility and transfer (including guiding) when a participant can at least partially bear own weight
- Medication, including assisting with the self-administration of medicine, such as opening bottles, and getting water
- Shopping for groceries or household items specifically required for the health and maintenance of the participant
- Applying non-prescription topical ointments/lotions to unbroken skin

The encouragement and instruction of participants in self-care may be a component of any other task(s) as described above; however, encouragement or instruction alone does not constitute a task.

Advanced personal care (APC) services provide assistance with ADLs when such assistance requires devices and procedures related to altered body functions. These services are described in greater detail in [Section 2.7](#) of this manual.

Agency Model Personal Care Service Limitations

Per the personal care service definition above, personal care services are covered only in the participant's home. These services are not covered in a hospital or nursing facility. The only acceptable place of service code (POS) to use when filing claims is 12 (Home). Refer to [Section 4.6](#) of this manual for more information on POS codes.

Personal care providers delivering agency model services are not reimbursed for the following activities:

- Providing therapeutic/health-related activities that should be performed by a Registered Nurse (RN), Licensed Practical Nurse (LPN), or home health aide under Title XVIII or Title XIX Home Health Programs
- Providing transportation
- Accompanying the participant outside of the home
- Administering patent or prescribed medications
- Cleaning or cutting fingernails or toenails of a participant with diabetes or medically contraindicating conditions (i.e., participants taking anticoagulant medication, those diagnosed with a peripheral vascular disease, or have a compromised immune system), 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 (e.g., cleaning the entire living area if the participant occupies only one (1) small room)
- Cleaning spaces shared by members of the entire household
- When the task is such that members of a household may reasonably be expected to share or do for each another, unless the task is above and beyond typical activities that would be provided for a household member without a disability
- Laundry, other than that incidental to the care of the participant (e.g., laundering clothing and bedding for the entire household, as opposed to only doing the participant's laundry)
- 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 shopping for items needed by the participant but also used by the rest of the household.
- Personal care services provided by a member of the participant's family. Refer to the definition of family member in Section 2.1 of this manual
- Out-of-state personal care services

Agency personal care provides 'hands on' assistance with physical tasks that benefit the participant and are based on the physical limitations of the participant. Therefore, no time can be allotted for stand-by assistance, prompting, or cueing.

Provider Participation Requirements

Personal care providers, regardless of the model by which they deliver services, must have a valid Title XIX Participation Agreement in effect with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance Unit (MMAC).

To enroll as a personal care provider, the applicant must be one (1) of the following:

- An approved DSS, MMAC Title XX Social Services Block Grant (SSBG)/General Revenue (GR) provider. Providers must maintain their approval to participate as an SSBG/GR provider, whether or not they actually service SSBG/GR eligible participants.
- A RCF or ALF, licensed by the Department of Health and Senior Services (DHSS), Division of Regulation and Licensure. RCF/ALF personal care providers may only furnish personal care services to participants in their RCF/ALF. RCF/ALF personal care providers must maintain their RCF/ALF license.

To enroll, providers should email MMAC Provider Enrollment at:

MMAC.IHSContracts@dss.mo.gov. Refer to the MMAC [Home](#) and Community Based Services (HCBS) webpage for more information.

Electronic Visit Verification

In accordance with the 21st Century CURES Act and [13 CSR 70-3.320](#), providers are required to utilize an electronic visit verification (EVV) system to document services rendered related to the delivery of all Medicaid-funded in-home agency model and CDS model personal care services. EVV requirements do not apply to services provided in residential or group settings, such as RCFs or ALFs.

The EVV system must collect the following data elements:

- Type of service performed
- Individual receiving the service
- Date of the service
- Location of the service delivery when it begins and ends
- Individual providing the service
- Time the service begins and ends

The EVV system must have the ability to exchange data with the EVV Aggregator Solution (EAS) designated by DSS. It is the responsibility of each provider to register their contracted EVV vendor, log onto the EAS at least weekly to verify the vendor sends timely and accurate visit data to the EAS and report any suspected falsification of data to MMAC. Agencies with no data in the EAS for participants that have received Medicaid-funded in-home personal care services are out of compliance with EVV requirements.

During claims processing, claims for personal care services are matched to EVV data. The fields matched include the following:

- Participant designated client number (DCN)/MO HealthNet identification number (ID)
- Date of service
- Procedure code and/or modifier combination
- MO HealthNet provider ID

All EVV data must be available for inspection by DSS and DHSS. Providers found to be out of compliance with EVV requirements will be subject to administrative actions by MMAC. Refer to the [Electronic Visit Verification webpage](#) for more information, such as administrative rules and other announcements. For questions about EVV, contact AskEVV@dss.mo.gov.

Agency Model Participant Eligibility Requirements

To be eligible for personal care services, participants must:

- Have current eligibility for MO HealthNet benefits. Participants who are eligible for MO HealthNet coverage on a spend down basis may be authorized to receive personal care

services during periods when they meet their spend down liability. A participant is responsible for the cost of services received during periods of time when they have not met their spend down liability. Refer to the [General Sections Manual](#) for more information regarding spend down.

- Be assessed by DHSS or its designee to meet nursing facility level of care, such that the participant would require admission to a hospital or a long-term care facility if personal care services were not provided
- Have identified unmet needs and be willing to receive a comprehensive assessment from DHSS or its designee
- Be reassessed annually by DHSS or its designee to facilitate the determination of continued eligibility for HCBS and the amount of assistance authorized. Refer to [Section 2.17](#) of this manual for further information regarding provider re-assessor requirements.
- Have unmet needs that can be safely met at a cost that does not exceed the average monthly MHD cost of nursing facility care

The participant must be eligible for MO HealthNet services on the day the service is delivered, or the provider will not be reimbursed through MHD. This is a requirement even when the service has been prior authorized. It is the responsibility of the provider to verify the participant's MO HealthNet eligibility on the day the service is provided via [eMOMED](#) or by calling Provider Communications at (573) 751-2896 or toll-free at (833) 222-7916. Refer to the [General Sections Manual](#) for more information on participant eligibility.

Authorization of Personal Care Services

All units of Title XIX personal care services, whether delivered via agency or consumer-directed model, must be authorized by DHSS or its designee before services can be delivered.

The detailed care plan or authorization for services shows how many units of service are authorized and specifies the period of time covered by the authorization. In addition, the care plan includes a list that shows the specific service activities that must be performed, at a minimum, by the personal care attendant. Additional service activities may be performed if the time spent does not exceed the units authorized.

The authorization for services is based on participant needs identified during the initial assessment and reassessment processes. The needs of the participant must be reassessed at least annually, and the amount of assistance authorized will be maintained, adjusted or eliminated accordingly.

Refer to [Section 3](#) of this manual for more information about prior authorization (PA) and documentation requirements.

Coordination of Personal Care with Division of Developmental Disabilities

The Missouri Department of Mental Health (DMH), Division of Developmental Disabilities (DD), operates four (4) HCBS 1915(c) waivers for individuals with developmental disabilities. All four (4)

DD HCBS waivers include personal assistant services, including the option for self-directed personal assistant services.

The Centers for Medicare & Medicaid Services (CMS) does not allow waiver services to duplicate or supplant services covered by MO HealthNet and requires that when a service is available under MO HealthNet, the waiver may provide services beyond the scope of the State Plan.

Participants of any DD HCBS waiver who are also eligible for State Plan personal care may be authorized for both agency model state plan personal care and DD waiver personal assistant services in the following situations:

- State Plan personal care units have been exhausted and more assistance with ADLs and/or instrumental activities of daily living (IADLs) is needed
- Participant requires personal care at locations outside of their residence
- Participant has behavioral or medical needs that require a more highly trained personal assistant than is available under the State Plan Personal Care Program
- Participant is self-directing waiver personal assistant services through a DD Fiscal Management Services contractor

When participants receive both agency State Plan personal care and DD HCBS waiver personal assistant services, the DHSS service authorization system must coordinate closely with the local DD support coordinator. Participants cannot be authorized to receive both consumer-directed model State Plan personal care and DD HCBS waiver personal assistant services.

Refer to [DMH DD](#) for more information.

2.2 Agency Model Administrative Requirements

General Personnel Administrative Requirements

Providers must meet the following general administrative requirements for personnel:

- Adhere to provider requirements at 19 CSR 15-7.021(18)(A) through (Q) and (18)(T) through (W), and 13 CSR 70-91.010
- Document all staff qualifications in personnel records, such as verification of RN or LPN license, certified nurse assistant (CNA) certification, Graduate Nurse (GN) degree, which should include at least the license or certification number, post-secondary degree if required, or any required experience
- Establish, implement, and enforce a policy governing communicable diseases that prohibits provider staff contact with participants 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 DHSS (19 CSR 20-20.020), are carried out.

- Establish a grievance system through which a participant may present grievances concerning the operation of the personal care program. The provider must document the participant's receipt of information regarding the grievance procedures.
- Protect DSS and DHSS, their employees, agents, and/or representatives from any and all liability, loss, damage, cost, and expense which may accrue or be sustained by DSS and DHSS, 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 personal care program
- Establish, enforce, and implement a policy whereby all contents of the personnel files of its employees are made available to DSS and DHSS employees or representatives when requested as part of an official investigation of abuse, neglect, financial exploitation, misappropriation of participant's funds or property, or falsification of documentation which verifies service delivery
- Maintain bonding and personal and property liability insurance coverage on all employees and volunteers who are involved in delivering personal care services
- Ensure that all employees are registered with the DHSS Family Care Safety Registry (FCSR). The provider shall then request background information on all employees and abide by the rules set forth in 19 CSR 30-82.060 regarding any employees not eligible for employment.
- Conduct a criminal background screening as required in 192.2495, RSMo
- Check the DHSS Employee Disqualification List (EDL) or the FCSR, prior to employment for prospective employees, to ensure their names do not appear on the list. Providers may call the DHSS FCSR interactive voice response (IVR) system at (573) 522-6510 or access it on the DHSS EDL website. These automated systems will allow verification of the EDL status of applicants for employment, or current employees, and provide a confirmation number verifying that the required EDL check was performed. The systems are available for calls and website visits seven (7) days a week, 22 hours per day. System maintenance occurs between 2:00 a.m. and 4:00 a.m. each day.
- If it is found that a prospective employee is on the EDL, then that individual must not be considered further for employment
- If using the FCSR to conduct the EDL and criminal background screenings, providers must meet the statutory background screening requirements, provided there is sufficient documentation showing the identity of the person who was screened, the dates the screening was required and completed, and the outcome of the screening. Providers are encouraged to check each employee monthly against the Office of Inspector General's List of Excluded Individuals/Entities (LEIE) for current employees and prior to employment for prospective employees. All employee background screenings must be retained by the

provider either electronically or in paper form and must be made available upon request by MMAC or DHSS staff.

- Issue to each personal care aide, at time of employment, a permanent identification (ID) card that shows the provider's name and the aide's name and title. The provider shall require each personal care aide to carry the ID card to present to participants as necessary. The provider shall make every effort to repossess the ID 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 ID card.

Provider Service Delivery Standards

The following service delivery standards must be met by providers:

- Must have the capability to provide service outside of regular business hours, on weekends, and on holidays to provide services in accordance with the care plan for each participant. Service must be provided by qualified persons on the provider's staff.
- Shall accept participants based on a reasonable expectation that the participant's maintenance care needs can be met adequately by the provider in the participant's place of residence. Services must follow the care plan.
- Prior to the delivery of service, the personal care aide shall receive a copy of the care plan for the participant and be provided with information about the participant to appropriately deliver services to meet the needs of the participant.
- Must deliver the personal care services within 10 calendar days of receipt of the service authorization notification or on the beginning date specified by the authorization, whichever is later, and on a regular basis thereafter in accordance with the care plan. If service is not initiated within the required time period, a detailed written justification must be maintained in the participant's file. Providers are encouraged to upload the justification into the participant's electronic case record.
- Must comply with the applicable statutes and regulations regarding reports of abuse or neglect. 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. Refer to Missouri Adult Abuse and Neglect Hotline for more information.

Participant's Rights and Procedures

The provider shall have a written statement of the participant's rights 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 care 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 services without regard to race, creed, color, age, sex, or national origin
- Receive a copy of the code of ethics under which services are provided

Discharge Policies and Procedures

Personal care services for a participant shall be discontinued by a provider under the following circumstances:

- When the participant's case is closed by DHSS or its designee
- When the provider learns of circumstances that require the closure of a case for reasons including, but not limited to death, admission to a nursing facility, or the participant no longer needs services. In these circumstances, the provider shall notify DHSS or its designee, in writing, and request that the participant's services be discontinued.
- When the participant is noncompliant with the agreed-upon care plan. Noncompliance requires persistent actions by the participant, or their family/representative which negate the services provided in the care plan. After all alternatives have been explored and exhausted, the provider shall notify DHSS or its designee, in writing, and request that the participant's services be discontinued.
- When the participant or participant's family threatens and/or abuses the personal care aide and/or provider to the point where the staff's welfare is in jeopardy and corrective action has failed. The provider shall notify DHSS or its designee, in writing, and request that the participant's services be discontinued.
- When a provider is unable to continue to meet the maintenance needs of a participant because the care plan hours needed to ensure the health and safety of the participant exceed availability. In these circumstances, the provider shall notify DHSS or its designee, in writing, and request that the participant's services be discontinued.

When a provider is unable to continue to meet the maintenance needs of a participant or when a participant is noncompliant with the agreed-upon care plan, the provider shall provide written notice of discharge to the participant or participant's family and DHSS, at least 21 days prior to the date of discharge. DHSS shall be notified through a [Person Centered Care Plan Online Request](#). During this 21-day period, DHSS shall assist in making appropriate arrangements with the participant for transfer to another provider, institutional placement, or other appropriate care. Regardless of circumstances, the personal care provider must continue to provide care in accordance with the care plan for these 21 days or until alternate arrangements can be made by DHSS, or its designee, whichever comes first.

Discontinuing services for a participant still in need of assistance shall occur only after appropriate conferences with DHSS or its designee, the participant, and their family.

Provider Compliance

Personal care providers must have a valid Title XIX Participation Agreement in effect with MMAC to provide personal care services, pursuant to federal and state laws and regulations. MMAC may suspend or terminate the written agreement of any provider found to be out of compliance with the written agreement and with the provisions and/or requirements of applicable state laws and regulations.

Providers must notify the MMAC Provider Enrollment Unit at least 30 days before a change of ownership or control of the provider's business. The provider must notify MMAC within at least 90 days before any other changes, such as change in location, telephone number, administrative, or corporate status. The provider must notify MMAC by completing the [Home and Community Based Services Change Request](#) form. The request and supporting documentation should be faxed to (573) 634-3105.

MMAC conducts both program and fiscal monitoring of the Personal Care Program. Post-payment on-site and desk reviews (audits) may be announced or unannounced. Providers must comply with the provisions of [13 CSR 70-3.030](#), regarding providing documentation to MMAC, and must provide necessary information to conduct state and/or federal audits. MMAC may, in accordance with the protective service mandate ([Chapter 192, RSMo](#)), take action to protect participants from providers who are found to be out of compliance with statutory and regulatory requirements applicable to the Personal Care Program, when such noncompliance is determined by MMAC to create a risk of injury or harm to participants.

2.3 Agency Model Personnel Requirements

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 (1) of the following criteria before performing the supervisory duties required by these standards:

- Be an RN currently licensed in Missouri
- Have a baccalaureate degree
- Be an LPN, currently licensed in Missouri with at least one (1) year of experience with the care of the elderly, or individuals with disabilities or medically complex conditions

- Have at least two (2) years of experience in the care of the elderly, or individuals with disabilities or medically complex conditions

If the designated administrative supervisor is not an RN, the provider agency must have a designated RN currently licensed in Missouri on staff or employed as a consultant available to fulfill the specific functions described in the [Nurse Supervision Requirements](#) section.

Administrative Supervisor Duties

The duties of the designated administrative supervisor include, at a minimum, the following:

- Read a copy of the MO HealthNet Program requirements contained in [Section 2](#) of this manual. All nursing staff (RNs, LPNs, and GNs) and administrative supervisors must have documentation in their personnel files that they have been given and have read this section.
- Establish, implement, and enforce a policy governing communicable diseases that prohibits provider staff contact with participants when the employee has a communicable condition, including colds or flu. Assure that reporting requirements governing communicable diseases, including hepatitis and tuberculosis, as set by [19 CSR 20-20.020](#), are carried out.
- Monitor the provision of personal care services and authorized nurse visits to assure that services are delivered in accordance with the care plan. This shall be primarily in the form of an at least monthly review and comparison of the aides' records of provided services with the care plan. 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. The monitoring reports shall be available for review by DSS and DHSS upon request. Documentation, including the reason, must be kept on authorized services and units not delivered.
- Make an on-site visit at least annually to evaluate each personal care aide's performance and the adequacy of the care plan, including review of the care plan with the participant. The personal care aide may or may not be present for this evaluation. A written record of the evaluation shall be maintained in the personnel file of the personal care aide. This record must contain, at a minimum, the participant's name and address, the date and time of the visit, personal care aide's name, observations related to the participant's receipt of care plan delivery, the participant's satisfaction of the personal care aide's performance and the adequacy of the care plan, and must be signed and dated by the supervisor who prepared it and by the personal care aide. If the required evaluation is not performed or not documented, the personal care aide's qualifications to provide the service may be presumed inadequate and all payments made for services by that personal care aide may be recouped.

- Approve, in advance, all changes to the care plan based on supervisory on-site visits, information from the personal care aide, or observation by the RN, or a combination of these, as noted and dated in the participant's file
- Make appropriate recommendations to DHSS or its designee, including proposed increase, reduction, or termination of services, or need for increased DHSS involvement based on supervisory on-site visits, review of reports, information from the personal care aide, observation by the RN, or a combination of these
- Assist in orientation and personal care training for personal care aides
- Designate a trainer(s) to perform on-the-job training sessions required as part of the basic training of the personal care aide. The designated trainer(s) may be the personal care supervisor or a personal care aide who has been employed by a personal care provider at least half-time for a period of six (6) months. Refer to [Section 2.4](#) of this manual for more information on training requirements.
- Communicate with DHSS or its designee, regarding changes in any participant's condition and recommended changes in scope or frequency of service delivery. The provider must document such communication in the participant's file.
- Be available for regular case conferences with DHSS or its designee.

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
- Not be the family member of the participant for whom personal care is to be provided, as defined in [Section 2.1](#) of this manual.

Nurse Supervision Requirements

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

If the provider's designated 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 designated administrative supervisor.

If supervised by an RN, an LPN or GN may perform the RN supervisory activities described in this section.

2.4 Agency Model Training Requirements

All personal care aides, whether basic or APC aides, who provide services reimbursed by MHD must meet or have met the basic training and in-service training standards set forth in this section. APC aides have additional training requirements. Refer to [Section 2.7](#) of this manual for more information.

The cost of all training is part of the provider's administrative cost and is not separately billable.

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'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 following:

- Dates of all training
- Trainer's name
- Topics
- Number of hours
- Location
- Date of first participant contact; either supervised on-the-job training or unsupervised service delivery
- Aide's signature

Additional required documentation includes the following which 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 DSS and DHSS.

- Topical outline of each session's content
- Mode of training (classroom or on-the-job)
- Signature of the attendee(s)
- Deviations in content from the written plan noted and explained

When calculating training hours, a training hour is equal to 60 minutes.

If a waiver of basic training has been granted, the personal care aide's individual training report shall contain supportive data for the waiver. Refer to [Waiver of Basic Training](#) below for more information.

Basic Training

When individuals are newly employed as personal care aides, they shall receive a minimum of 12 hours of basic orientation training. The following requirements apply to this training:

- All basic training must be completed within 30 days of the first date of employment
- A minimum of six (6) hours of training must be completed prior to the first participant contact
- At least two (2) hours of basic training must include orientation to the provider and the provider's protocols for handling emergencies
- Reading materials shall constitute no more than two (2) of the total 12 hours

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 their estate including power of attorney, conservatorship, or guardianship
- Taking anything from the participant or from the participant's home
- Committing any act of abuse, neglect, or exploitation

Training Contents

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

- Organization, purpose, and philosophy of the personal care provider
- Relationship of the provider to the appropriate state agency, or its designee, and MHD
- 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
- 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
- Review of infection control and universal precaution procedures as defined by the Centers for Disease Control and Prevention (CDC)

Waiver of Basic Training

Experience or Aide Certification

The provider may waive four (4) hours of the required training with adequate documentation in the employee's records that the aide received similar training during the previous 12 months, with the exception of the statutorily required dementia training. The six (6) hours of training prior to participant contact must include two (2) hours of provider agency orientation.

Refer to **In-Service Training** below for more information on dementia training.

Licensed Nurse/Certified Nurse Assistant

All hours of basic training, with the exception of the two (2)-hour provider agency orientation and the statutorily required dementia training, may be waived, with adequate documentation in the aide's personnel record that the aide is an RN, LPN, or CNA. The documentation shall include the employee's license or certification number, which must be current and in good standing at the time the training was waived.

Refer to [In-Service Training](#) below for more information on dementia training.

Provider Verification

It is ultimately the provider's responsibility to determine whether the previous training was sufficient to allow 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:

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

Supervised On-The-Job Training Review

The on-the-job training review shall consist of the observation of the aide's performance of hands-on personal care tasks under the direction of a designated trainer. The designated trainer(s) may be the RN, LPN, GN, supervisor or an experienced aide who has been employed by the provider agency at least six (6) months. 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 supervised on-the-job training review should include observed demonstration of personal care tasks such as:

- 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 participants without contraindicating conditions
- Applying non-prescription topical ointments/lotions to unbroken skin at the participant's direction

The designated trainer must document that the aide can successfully perform demonstrated tasks. This documentation must be filed in the aide's personnel record.

In-Service Training

All personal care aides shall receive a total of five (5) hours of in-service training annually after the first 12 months of employment.

The provider may waive the required annual five (5) hours of in-service training and require only two (2) hours of refresher training annually, when the aide has been employed for three (3) years and has completed 15 hours of in-service training that meets the standards set forth in this section. In-service training curricula shall include updates on Alzheimer's disease and related dementia per [192.2000, RSMo](#). 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 individuals with disabilities
- Recognizing and reporting abuse or neglect
- Acquired Immunodeficiency Syndrome (AIDS) education
- Alzheimer's and related dementia, as required per [192.2000.7, RSMo](#)
- Death and dying

2.5 Agency Model Records Requirements

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

- Coordination with other providers
- Non-discrimination based on disabilities
- Administrative policies and procedures

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 care plan authorization from the participant's electronic case record, which documents authorization for all units of service provided. Refer to [Section 3.1](#) of this manual for more information.
- Documentation of undelivered services
- For RCFs and ALFs, the personal care aide's name, participant's name, dates of service delivery, and activities performed on each date. All paid units of service must be documented. Reference [13 CSR 70-91.010\(4\)\(A\)2.A-F](#) for additional documentation requirements. 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 DSS and DHSS.
- Documentation of all correspondence and contacts with the participant's physician or other care providers
- Any other pertinent documentation regarding the participant
- 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.

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 education and work experience
- The aide's date of birth, date of employment, and the date the provider terminated the aide (if applicable)
- For supervisory staff, documentation that they have been provided with and have read [Section 2.3](#) of this manual
- Documentation of basic and in-service training received (individual training report; reference [Section 2.4](#) of this manual)
- Documentation of any waiver or reduction of employment or training requirements (reference [Section 2.4](#) of this manual)

- Annual performance evaluation which includes observations from at least one (1) on-site visit (reference [Section 2.3](#) of this manual)
- 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 aide's position, including whether the employee performs administrative duties for the provider or delivers services to participants
- Returned ID card for a terminated personal care aide, or documentation of why it is not available

The provider must also maintain the written plans for basic and in-service training. Refer to [Section 2.4](#) of this manual for more information.

Required Documentation

HCBS in-home agency personal assistant providers must have an EVV system in place. Refer to [Section 2.1](#) of this manual and the [Electronic Visit Verification](#) webpage for additional information regarding EVV for in-home agency services.

Care plan tasks should be delivered as outlined in the care plan. For example, if a task is scheduled for three (3) days per week, it should be scheduled, delivered, and documented through EVV as delivered three (3) times per week. Scheduled personal care aide/attendant time will likely vary from day to day based on the task frequency outlined in the care plan. Care Plan unit totals should not be evenly distributed across the maximum number of days on a care plan to determine scheduling time.

The provider shall not submit claims solely based on the PA but must base claims upon documentation of actual services rendered. The participant may have been in the hospital or nursing facility 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. Upon completion of delivery, EVV documentation should reflect the actual tasks delivered and should closely align with the authorized task frequencies. There may be instances in which deviation from the care plan is needed to accommodate a participant's needs. These instances are expected, but consistent need to deviate on a task should prompt a request to the care plan change team for updated needs.

RCF/ALF personal assistant providers are not required to use EVV; however, they must document the following:

- The date of service
- The time spent providing the service, documented by one (1) of the following methods:
 - Actual clock time of the start and actual clock time of the end of any period of uninterrupted one (1)-on-one (1) service to a single individual. For example, if a

personal care aide is providing services to one (1) individual and devotes undivided attention to the care required by that individual, the actual clock time the aide began the services is the start time, and the actual clock time the aide finished the care is the end time. (For example: 9:30 a.m. to 10:30 a.m.)

- When the personal care aide divides their time among several individuals, all tasks performed for each participant by date of service and by staff shifts during each 24-hour period must be documented
- Any other method that includes all required elements of documentation listed in this section
- A description of the service (specific tasks)
- The name of the personal care aide who provided the service
- The participant's name and MO HealthNet ID/DCN
- DHSS calculates a participant's maximum monthly personal care units based on the exact number of days in that specific month. .

2.6 Authorized Nurse Visits

The authorized nurse visit is a covered service under the MO HealthNet Personal Care Program. Reimbursement is made for supervision of the Personal Care Program, in addition to the visits by a nurse to participants with medically-oriented needs, when such visits are prior authorized by DHSS Division of Senior and Disability Services (DSDS) or its designee, or the Bureau of Special Health Care Needs (BSHCN).

Providers of in-home agency 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 nursing services that may be authorized in the participant's home are services of a maintenance or preventative nature provided to participants 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 provider nurse detect a need for services that meet the definition of reimbursable skilled nursing care under the Home Health Program, the provider nurse must alert the participant's physician and the appropriate state agency or its designee. The physician may then refer the participant to a home health agency for treatment.

Refer to the [Home Health Provider Manual](#) for more information.

To be eligible for the authorized nurse visit, the participant must meet the following criteria:

- Receive a personal care service

- Have a documented need for the authorized nurse visit
- Have no adequate support system that could provide these services

Authorized nurse visits are limited to 26 within a six (6)-month timeframe.

Authorized Nurse Services

The purpose of authorized nurse visits is to provide increased supervision to the personal care aide and maintenance or preventative services, assessment of the participant, and the suitability of the care plan to meet the participant's needs. The authorized nurse visit is used for APC care plan development, on-the-job training for the APC aide, monthly evaluation of APC participants, and to meet identified ongoing nursing needs. All APC participants must have at least one (1) authorized nurse visit per month. Refer to [Section 2.7](#) of this manual for more information on APC services.

Authorized nurse visits shall also include any referrals or follow-up action indicated by the nurse's assessment. In addition, these visits must include one (1) or more of the following where appropriate to the needs of the participant and authorized by the appropriate state agency:

- Filling insulin syringes in advance per manufacturer's instructions for a participant with diabetes who can self-inject the medication but cannot fill their own syringe. This service includes monitoring the participant's continued ability to self-administer the insulin.
- Providing medication set up, management, and/or oversight, which may include setting up oral medications for self-administration and assessing for any adverse reactions, compliance issues, dosing adjustment needs, or overall effectiveness of the medication
- Monitoring a participant's skin condition when a participant is at risk of skin breakdown
- Providing nail care for a participant with diabetes or other medically contraindicating conditions who is unable to perform this task, such as:
 - Circulatory or neurologic deficiency
 - Taking anticoagulant medications, such as Coumadin
 - Diagnosed with peripheral vascular disease
 - Diagnosed with compromised immune system, such as from human immunodeficiency virus (HIV) or chemotherapy
 - Issues related to deformity of the foot
 - Perform a General Health Evaluation (GHE) at least twice annually to assess the participant and the participant's care plan using the [General Health Evaluation and Level of Care Recommendation](#) form. GHEs should be performed on the 4th and 10th month following the annual assessment and shall be uploaded into the DSDS electronic case management system by the 15th of the following month. If the participant is identified as needing a change in their care plan, whether an increase or decrease in

services, the nurse shall notify the DSDS Person Centered Care Planning team with the recommended changes.

The authorized nurse visits listed above may be provided by an LPN or GN, if under the direction of an RN or physician. The services provided during the authorized nurse visit shall not include any service which the participant 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 participant otherwise be eligible for home health services, the above services 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 consistently needs more or fewer units than were authorized, the nurse shall provide a written recommendation to revise the care plan .

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 2.2](#) of this manual.

The provider 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; refer to [Section 2.14](#) of this manual for more information
- Activities which shall or shall not be performed
- Infection control and universal precaution procedures as defined by the CDC
- Record keeping requirements and reporting forms required by the personal care provider or state agency, or its designee who authorized the service
- OSHA standards regarding precautions to be taken to avoid risks associated with bloodborne pathogens
- Communicating with the appropriate state agency or its designee and taking appropriate action on clinical changes in the participant's condition

Authorized Nurse Visit Records

Written notes concerning the authorized nurse 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 or its designee concerning the care of that participant is also maintained in the participant's file.

2.7 Advanced Personal Care Services

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

APC is a maintenance service and should never be used as a therapeutic treatment. Participants who develop medical complications requiring skilled nursing services while receiving APC services shall 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 this section also apply to the APC 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 APC services.

APC providers are required to perform the following service tasks to meet participants' needs:

- 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 the ostomy or catheter site.
- Removal of external catheters, inspection of skin, and reapplication of catheter
- Administration of prescribed bowel program, including use of suppositories and sphincter stimulation and enemas (pre-packaged only) for participants without contraindicating rectal or intestinal conditions
- Application of medicated (prescription) lotions, ointments, or dry, non-sterile dressings to unbroken skin
- Use of a lift or other device for transfers
- Manual assistance with oral medications which are set up by a nurse
- Passive range of motion (non-resistive flexion of joint within normal range) delivered in accordance with the care plan, unless contraindicated by underlying joint pathology
- Application of non-sterile dressings to superficial skin breaks or abrasions as directed by a nurse

Advanced Personal Care Provider Participation Requirements

Providers choosing to deliver APC services must have a valid Title XIX Participation Agreement in effect with MMAC, as referenced in [Section 2.1](#) of this manual. In addition, the provider must sign the [MO HealthNet Personal Care Program Addendum to Title XIX Participation Agreement for Personal Care Services](#), indicating their agreement to provide APC services.

Only those personal care providers meeting one (1) of the following requirements may be authorized to provide APC services:

- Title XX (Social Service Block Grant) providers whose contract includes APC services
- An RCF or ALF licensed by DHSS Division of Regulation and Licensure

Upon approval of the provider enrollment application, RCF/ALF APC providers may only furnish APC services to participants in their RCF/ALF. If an RCF/ALF provider wants to provide APC services in the community, it must submit a proposal to:

MMAC Contracts Unit
PO Box 6500
Jefferson City, MO 65102-6500

Providers must receive approval from MMAC as a Title XX Social Service Block Grant (SSBG) provider before services can be approved.

The [MO HealthNet Personal Care Program Addendum to Title XIX Participation Agreement for Personal Care Services](#) and verification of the Title XX contract should be submitted to MMAC.IHSContracts@dss.mo.gov, faxed to (573) 634-3105, or mailed to:

MMAC Contracts Unit
PO Box 6500
Jefferson City, Missouri
65102-6500

Providers may contact MMAC at MMAC.IHSContracts@dss.mo.gov, (573) 751-3399, or toll-free (833) 818-1183 for information regarding the SSBG provider program and enrollment.

Advanced Personal Care Participant Minimum Needs Criteria

In addition to meeting the eligibility requirements of the Personal Care Program listed in [Section 2.1](#) of this manual, the participant must have the following:

- Documented need for the APC service(s)
- No adequate support system that could provide these services to the participant
- Qualifying stable, chronic condition
- Need for assistance with ADLs when such assistance requires devices and procedures related to altered body functions

For children, reference [Section 2.13](#) and [Section 2.14](#) of this manual for more information. For persons with AIDS/HIV, reference [Section 2.15](#) of this manual for more information.

Authorization of Advanced Personal Care

All units of APC must be authorized by DHSS or its designee before services can be delivered. The care plan must be developed, reviewed, and updated by the provider's RN in cooperation with the state agency or its designee. For APC services authorized by BSHCN for children (age 0-20 years), the APC care plan must be updated every six (6) months.

Advanced Personal Care Registered Nurse Supervision

RN supervision is essential to the safe provision of APC services. Certain nurse functions for APC participants may be performed by an LPN or GN; others must be performed by an RN. The following outlines the nursing requirements for APC participants:

The RN shall:

- Conduct an initial visit to assess and evaluate the care plan for participants with APC needs, in collaboration with the state agency staff or its designee. The provider may request a change in the care plan if determined through this initial assessment. A [care plan change request](#) should be made to the PCCP Team. This visit may be authorized and billed to MHD as an authorized nurse visit.
- Conduct on-site visits to all APC participants at intervals no greater than six (6) months. During the visit, the RN must conduct and document an evaluation of the participant's condition, continued eligibility for the program, and the adequacy of the care plan. The RN must sign the evaluation, and the provider shall maintain documentation of the evaluation in the participant's record. The evaluation must be produced upon request of DSDS or MMAC.
- Be available, at least by telephone, during any period of time APC is being provided

The RN or an LPN or GN, under the direction of the RN, shall:

- Conduct the monthly APC evaluation to evaluate the adequacy of service delivery and ensure the participant's needs and conditions are met. The evaluation must be maintained in the participant's file. If issues are identified, the nurse shall take appropriate action to ensure the participant's needs are being met.
- Provide on-the-job training and competency testing for APC aides. This includes observing the aide is successfully performing each APC task during an on-the-job training session and documenting the successful completion of each task in the aide's personnel record. This visit may be authorized and reimbursed. An LPN or GN may observe and certify the successful completion of each APC task only if they have been trained in the APC tasks and observed by the RN supervisor for successfully completing each task, and have this documented by the RN supervisor in their personnel record.

Advanced Personal Care Aide Requirements

In addition to meeting the basic personal care aide requirements discussed in [Section 2.3](#) of this manual, all APC aides employed by the provider must:

- Not be a family member of the participant for whom personal care is to be provided, as defined in [Section 2.1](#) of this manual; and
- Be an LPN or a CNA; or
- Be a competency-evaluated home health aide having completed both written and demonstration portions of the test required by DHSS and [42 CFR 484.80](#); or
- Have successfully completed personal care aide training

Advanced Personal Care Aide Training

APC aides must receive a minimum of six (6) hours of APC training, prior to the provision of any APC tasks, in addition to the required basic training for personal care aides as described in this manual. The provider shall have written plans of the training; such training must include at a minimum the following topics:

- Observation of the participant and reporting observations
- Application of ointments/lotions to unbroken 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, sphincter stimulation)
- Passive range of motion exercises
- Use of assistive device (i.e., lifts, transfer boards) for transfers
- Positioning and support of the participant
- Applying non-sterile dressings to superficial skin breaks
- Universal precaution procedures as defined by the CDC

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

Waiving Training Hours

The provider may waive the six (6) hours of APC training if one (1) of the following conditions is met:

- The proposed APC aide is a CNA or an LPN currently licensed or registered in Missouri

- The proposed APC aide has previously completed APC training from a Missouri Medicaid in-home provider agency and has been employed by a Missouri Medicaid in-home provider as an APC aide within the prior six (6) months

If the waiver of APC training has been granted, documentation that the above conditions have been met must be placed in the aide's personnel record and be available for inspection by DSS and DHSS.

Demonstration of Competency

Prior to performing any APC task for any participant for the first time, the APC aide who is not a licensed nurse must demonstrate competency, specifically for the APC tasks as they appear on a participant's care plan. This competency must be demonstrated in an on-the-job training session conducted by an RN, LPN, or GN. The RN, LPN, or GN must document the aide's competency in performing each task in the aide's personnel file.

The required demonstration of each APC task during an on-the-job training session with an RN, LPN, or GN may not be waived, unless the APC aid is a licensed nurse. RN, LPN, or GN visits necessary for task observation and certification in the home may be prior authorized and billed to MHD as an authorized nurse visit. RN, LPN, or GN task observation and certification in a laboratory, or other non-home setting, may not be billed.

The RN, LPN, or GN may observe the execution of any of the tasks in a participant's home or lab setting. However, it is the responsibility of the provider to ensure the aide is properly trained to execute tasks that may have variation from the lab setting to the participant's home setting.

Annual In-Service Training

APC aides must receive five (5) hours of annual in-service training, the same as any personal care aide, as described in [Section 2.4](#) of this manual.

Advanced Personal Care Records

Providers participating in the delivery of APC 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 APC services must be maintained by participating providers.

Advanced Personal Care Aide Personnel Record

The aide's personnel record shall contain:

- Documentation of the six (6) hours of APC training including dates and topics
- Documentation for any waiver of the six (6) hours of APC training
- Signed statement(s) by the RN, LPN, or GN, certifying that the aide has successfully completed on-the-job training for each APC task the aide is required to perform

Advanced Personal Care Participant Record

The case record of any participant receiving APC services shall include:

- Written notes concerning any authorized nurse visits including the six (6)-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 the following:
 - Proof that 21-day notification was given to DHSS or its designee and APC participant prior to the date of closing
 - Participant's authorization date
 - Most recent care plan including identified functional disabilities
 - Reason for closing
 - Date of closing
 - Follow-up plan, if applicable

2.8 Consumer-Directed Services Model General Information

Consumer-Directed Services (CDS) is an alternative model in which a HCBS participant can receive personal care services. Under the CDS model, the participant (often referred to as the consumer) is responsible for hiring, training, supervising, and directing the personal care attendant. This model is designed to promote independence and additional choices for consumers.

Authorization of CDS is funded through both the State Plan Personal Care Program and the 1915(c) HCBS waiver titled Independent Living Waiver (ILW). DHSS/DSDS is responsible for authorizing both CDS options. This provider manual addresses State Plan Personal Care Program services only. Refer to the [Independent Living Waiver Provider Manual](#) for information regarding ILW.

Requirements and responsibilities for both CDS consumers and providers are established in [19 CSR 15-8](#).

Consumer-Directed Services Personal Care Tasks

Transportation assistance for essential shopping, errands, school, or employment is an allowable CDS task when the participant has an identified need for personal care assistance, even if that is met by supports other than CDS.

Refer to [Section 2.1](#) and [Section 2.7](#) of this manual for examples of basic personal care tasks and APC tasks that may be authorized under CDS.

Consumer-Directed Services Service Limitations

All CDS consumers must be capable of living independently (reside in a non-institutional or unsupervised residential setting) with CDS in place.

CDS shall not be authorized to pay for services when:

- The primary benefit is to a household unit
- The task is something that members of a household may reasonably be expected to share or do for each other, unless the task is above and beyond typical activities that would be provided for a household member without a disability

CDS provides 'hands on' assistance with physical tasks that benefit the consumer and are based on the physical limitations of the participant. Therefore, no time can be allotted for:

- Stand-by assistance, prompting, or cueing
- Respite care or for time spent waiting for a consumer at a physician's office, or any other appointment
- Any task that must be performed/trained by a licensed professional (i.e., skilled nursing, therapies ordered by a physician)

An individual with a physical disability and a cognitive impairment who can self-direct but chooses to delegate self-direction tasks may only be authorized for CDS through ILW. Participants who elect delegated self-direction cannot be authorized for CDS through the State Plan.

Individuals authorized for any type of residential habilitation services through DMH shall not be authorized for CDS as outlined in this policy. Individualized Supported Living (ISL) is considered a residential habilitation service. If the participant is enrolled in CDS, they cannot also participate in DMH Division of DD self-directed services.

Consumer-Directed Services Provider Participation Requirements

CDS providers must have a valid MO HealthNet Title XIX Participation Agreement in effect with MMAC, and must adhere to the standards for notification of provider changes and updates. Refer to [Section 2.2](#) of this manual for further information on provider participation and notification requirements.

Consumer-Directed Services Electronic Visit Verification

In accordance with the 21st Century CURES Act and [13 CSR 70-3.320](#), providers are required to utilize an EVV system to document services rendered related to the delivery of in-home services for all Medicaid-funded personal care services. The EVV system must have the ability to exchange data with the EVV Aggregator Solution. Refer to [Section 2.1](#) of this manual for additional information regarding EVV.

Consumer-Directed Services Consumer Eligibility Requirements

In addition to participant eligibility requirements listed in [Section 2.1](#) of this manual, CDS consumers must meet the following eligibility criteria:

- Be at least 18 years of age
- Have a physical disability (loss of, or loss of use of, all or part of the neurological, muscular, or skeletal functions of the body to the extent that the person requires the assistance of another person to accomplish routine tasks)
- Be able to self-direct their own services/care (consumer-directed)
- Be capable of living independently with CDS in place

Authorization of Consumer-Directed Services

All units of Title XIX personal care CDS model services must be authorized by DHSS or its designee before services can be delivered. Refer to [Section 2.1](#) and [Section 3.1](#) of this manual for additional information regarding authorization of services.

2.9 Consumer-Directed Services Model Administrative Requirements

Consumer-Directed Services Consumer Responsibilities

CDS consumers are responsible, at a minimum, for the following:

- Selection, hiring, training, and supervision of the personal care attendant
- Allowing the use of an EVV system that documents in-home personal care services delivery, in accordance with [13 CSR 70-3.320](#)
- Ensuring task frequencies and durations closely align with the authorized care plan
- Ensuring that units submitted for reimbursement do not exceed the amounts authorized by the CDS care plan and/or those eligible for reimbursement through MHD
- Promptly notifying DSDS and/or the provider within 10 days of any changes in circumstances affecting the CDS care plan and/or changes in their place of residence
- Promptly notifying the provider of any problems resulting from the quality of services rendered by the attendant. Any problems not resolved with assistance from the provider shall be reported to DSDS.
- Providing the provider with all necessary information to complete required paperwork for establishing the employer identification number
- Allowing the provider to comply with its quality assurance and supervision process, which shall include, but not be limited to, annual face-to-face home visits and monthly case management activities

- Reporting to DSDS significant changes in their health and ability to self-direct care by contacting the provider and/or DSDS

Consumer-Directed Services Provider Administrative Requirements

CDS providers must designate to MMAC the CDS manager who will be responsible for the provider's day-to-day operation. Refer to [Section 2.10](#) of this manual regarding specific CDS personnel requirements for the CDS manager.

CDS providers must implement a quality assurance and supervision process that ensures program compliance and accuracy of records, including ensuring the CDS manager adheres to the personnel requirements in [Section 2.10](#) of this manual, and maintaining documentation of successful completion of such requirements.

CDS providers must have a written pandemic preparedness policy to be followed when service delivery must be interrupted due to a pandemic, and providers must distribute their pandemic preparedness policy to all consumers annually. Providers must train all consumers and attendants on the policy at least annually.

CDS providers must perform, directly or by contract, payroll and fringe benefit accounting functions for consumers, including but not limited to:

- Utilizing an EVV system to document in-home personal care services rendered, in accordance with [13 CSR 70-3.320](#), collecting EVV records and verifying accuracy
- Transmitting individual payments directly to the personal care attendant on behalf of the consumer
- Ensuring all payroll, employment, and other taxes are filed and paid timely under the consumer's tax ID number
 - The provider shall be liable to the consumer for any garnishment action occurring as a result of the provider's failure to pay payroll, employment, or other taxes timely on behalf of the consumer
 - The provider shall notify the consumer of any communications or correspondence from any federal, state, or local tax authority of any overdue or unpaid tax obligation, as well as any notice of an impending garnishment
 - The provider may be subject to a monetary penalty per occurrence of the provider's failure to timely pay payroll, employment, or other taxes on behalf of the consumer

In addition to the above requirements, CDS providers are responsible, directly or by contract, for the following:

- Completing the MHD reimbursement process, including the filing of claims and reporting data to MHD as required by rule
- Maintaining a list of eligible attendants:

- Ensuring that each attendant is registered, screened, and employable according to the FCSR, the OIG, and the EDL maintained by DHSS, and applicable state laws and regulations prior to beginning service delivery
- Notifying the attendant of their responsibility to comply with applicable state laws and regulations regarding reports of abuse or neglect
- Attendants must meet the CDS attendant personnel requirements as outlined in [Section 2.10](#) of this manual
- Training and orientation of consumers in the skills needed to recruit, employ, instruct, supervise, and maintain the services of attendants. Refer to [Section 2.11](#) of this manual for further information regarding CDS consumer training requirements.
- Processing of consumers' and/or attendants' inquiries and problems
- Performing public information, outreach, and education activities to ensure that persons with disabilities are informed of the services available and have maximum opportunity for participation
- Maintaining confidentiality of consumer records, including eligibility information from DSDS, according to applicable federal and state laws and regulations
- Performing ongoing monitoring of the provision of services in the care plan and assessing the quality of care being delivered. Such monitoring shall include:
 - At least one (1) annual face-to-face visit in the participant's home as outlined in [Section 208.918, RSMo](#). Face-to-face is defined as an interaction that occurs in person and does not include interactions that occur through telecommunication or electronic technologies. Face-to-face visits shall be completed within 365 days from original authorized care plan, and annually thereafter. Documentation of each face-to-face visit must contain, at a minimum, the following:
 - Name of the monitoring individual
 - Those present at the time of the visit
 - Service delivery evaluation summary
 - Quality of care being delivered
 - Date and time of the visit

All documentation must be maintained in the consumer's case file and shall be made available to DHSS upon request. The provider shall report to DHSS if services are not being provided to the consumer as authorized in the care plan, which may result in suspension of services to the consumer.

- Monthly case management activities which must be completed by telephone, videoconference, or in-person with the consumer
- Other monitoring may include electronic monitoring, telephone checks, written case notes, or other DHSS-approved methods. The ongoing monitoring shall not preclude the provider's responsibility of ongoing diligence of case management activity oversight.
- Ensuring the consumer has an emergency and/or back up plan
- Reporting to DHSS significant changes in the consumer's health or ability to self-direct care
- Ensuring that the consumer's case file contains, at a minimum, the required documentation outlined in [Section 2.12](#) of this manual
- Adhering to the CDS provider service delivery standards outlined in this section

CDS providers must comply, directly or by contract, with the following fiscal requirements:

- No state or federal funds shall be authorized or expended to:
 - Pay for CDS if the primary benefit of such services is to the household unit, or is a task that members of the consumer's household may reasonably be expected to share or do for each another, unless such service is above and beyond typical activities household members may reasonably provide for another household member without a disability
 - Pay for CDS provided by an attendant who is listed on any of the background check lists in the [Family Care Safety Registry](#) pursuant to applicable state laws and regulations, unless the attendant first obtains a [Good Cause Waiver](#) from DHSS in accordance with applicable state laws and regulations
 - Pay for personal care assistance services if any direct employee of the CDS provider conducts the face-to-face home visit of a consumer for whom such employee is also the attendant, unless such person provides services solely on a temporary basis on no more than three (3) days in a 30-day period. The certified manager shall maintain records and provide to MMAC upon request.
- The general assembly shall set the statewide reimbursement rate to be paid for CDS
- The total monthly payment for CDS made on behalf of a consumer shall not exceed sixty percent (60%) of the average statewide monthly cost for care in a nursing facility as defined in applicable state laws and regulations
- Assure that federal funds shall not be used to replace funds from non-federal sources and that the provider shall continue or initiate efforts to obtain support from private sources or other public organizations

- Be responsible for repayment of any federal or state funds that are deferred and/or ultimately disallowed
- Submit CDS Quarterly Financial and Service Reports to MMAC 30 days after the end of each calendar quarter
- Submit an Annual Service Report to MMAC by January 30th of the following year (Example: report for 2024 due January 30, 2025)
- Maintain CDS financial records separately from any other financial records and make all consumer and CDS financial records, documents, reports, and data available to MMAC upon request
- Submit an annual audit or review by a properly licensed independent practitioner (certified public accountant licensed in the State of Missouri) pursuant to applicable federal and state laws and regulations, including any audit parameters as established by DHSS. Providers must adhere to the following requirements pertaining to the annual audit or review:
 - An annual financial statement audit is required if the provider's annual gross revenue is \$200,000 or more
 - An annual financial statement audit or annual financial statement review is required if the provider's annual gross revenue is less than \$200,000
 - The audit report must be submitted to MMAC within 150 days after the end of the provider's fiscal year

Consumer-Directed Services Provider Service Delivery Standards

In addition to the provider service delivery standards outlined in [Section 2.2](#) of this manual, CDS providers must comply with the following:

- Have a philosophy that promotes the consumer's ability to live independently in the most integrated setting. This philosophy includes the following independent living services:
 - Advocacy
 - Independent living skills training
 - Peer counseling
 - Information and referral
- Operate programs, services, and/or activities in such a manner as to be readily accessible to and usable by persons with disabilities
- Demonstrate a positive impact on consumer outcomes regarding the provision of CDS, by submitting quarterly service reports and an annual service report to MMAC

- Adhere to applicable statutes and regulations regarding reports of misappropriation of a consumers' property or funds or the falsification of documents verifying CDS delivery

Consumer-Directed Services Consumer's Rights and Procedures

CDS providers shall have a written statement of the consumer's rights to be given to each consumer at the time service is initiated. Refer to [Section 2.2](#) of this manual for more information.

Consumer-Directed Services Discharge Policies and Procedures

The following CDS discharge policies and procedures are in addition to those outlined in [Section 2.2](#) of this manual.

Upon discovery, CDS providers shall refer the following situations that may require closure or termination of services to DSDS for investigation:

- Inability of the consumer to self-direct
- Significant changes which would result in the need of a change in the authorized care plan for the consumer

CDS providers, after giving notice to DSDS may suspend services to consumers in the following circumstances:

- The personal care attendant witnesses significant deterioration of the health of the consumer or has a belief that the consumer is no longer capable of self-directed care
- Falsification of records or fraud, including providing false information of their condition(s), functional capacity, or level of care needs during the assessment that resulted in an authorization of services not needed
- Persistent actions by the consumer of noncompliance with the care plan, which negate the services provided in the care plan, and all alternatives have been explored and exhausted
- The consumer or a member of the consumer's household threatens and/or abuses the attendant and/or provider to the point where the staff's welfare is in jeopardy and corrective action has failed
- The attendant is not providing the services outlined in the CDS care plan and attempts to remedy the situation have been unsuccessful

Providers shall provide written notice to DSDS and the consumer, listing the specific reasons for requesting the closure, termination, or suspension. All supporting documentation must be maintained in the consumer's case file. DSDS shall investigate the circumstances reported by the provider and assist the consumer in accessing appropriate care. If the investigation concludes that such circumstances exist, DSDS may close or terminate services.

Consumer-Directed Services Provider Compliance

In addition to the provider compliance requirements outlined in [Section 2.2](#) of this manual, CDS providers must:

- Provide proof of maintaining a business location that complies with all applicable city, county, state, and federal requirements upon request of MMAC
- Have staff on the premises of the principal place of business that have access to records during business hours as prescribed by the provider's written participation agreement with MMAC

2.10 Consumer-Directed Services Model Personnel Requirements

The CDS attendant is an employee of the consumer only for the time period subsidized with CDS funds, but is never the employee of the provider, DHSS, or the State of Missouri. CDS attendants must meet the following qualifications:

- Be at least 18 years of age
- Be able to meet the physical and mental demands required to perform specific tasks required by a particular consumer
- Agree to maintain confidentiality
- Be emotionally mature and dependable
- Be able to handle emergency-type situations
- Be a person other than the consumer's spouse or guardian
- Not be a consumer
- Have not been involved in Medicaid fraud previously

The CDS manager is responsible for the provider's day-to-day operation. This manager must:

- Be a policy maker and supervise the provider's record keeping, service delivery verification, training and orientation of consumers in skills needed to recruit, employ, instruct, supervise, and maintain the services of attendants
- Successfully complete (or have completed) the CDS certified manager orientation and test offered by MMAC. Completion of the test for all new managers is required within six (6) months of hire
- Annually attend a MMAC-sponsored training update CDS meeting

CDS providers and managers must maintain documentation of attendance for all training, testing and meetings. Refer to [IHS Designated Manager and Certified CDS Manager Training/Testing](#) for more information.

2.11 Consumer-Directed Services Model Consumer Training

Documentation must be kept in the CDS consumer's file regarding training provided to the consumer in the skills needed to understand and perform the essential functions of an employer.

Training and orientation of consumers in the skills needed to recruit, employ, instruct, supervise, and maintain the services of attendants include, but are not limited to:

- Assisting consumers in the general orientation of attendants as requested by the consumer. To the fullest extent possible, this shall take place in the presence of the attendant.
- Federal and state requirements regarding the mandatory use of EVV to document services delivered; refer to [Section 2.1](#) of this manual for more information on EVV requirements
- Identification of issues that would be considered fraud, including falsification of attendant visit verification records, and notification to the consumer that such issues shall be reported to MMAC
- Responsibility of the consumer to report fraud to DHSS and/or MMAC
- Allowable and non-allowable tasks
- Rights and responsibilities of the attendant
- Identification of abuse, neglect, and/or exploitation
- The attendant shall report to the provider and/or the DHSS PCCP Team through the [PCCP Online Request](#) if they witness significant deterioration of the health of the consumer or if they have a belief that the consumer is no longer capable of self-directed care. Failure of the attendant to report this information should be reported by the provider to DHSS.

CDS consumers must receive training at least annually regarding the provider's pandemic preparedness policy to be followed when service delivery must be interrupted due to a pandemic. Refer to [Section 2.9](#) of this manual for more information regarding this provider requirement.

2.12 Consumer-Directed Services Model Consumer Records

Consumer-Directed Services Consumer Case Record

CDS providers are required to document, at a minimum, the following in CDS consumer case files:

- Employee Identification Number (EIN)
- Missouri Tax ID
- Internal Revenue Service (IRS) 2678 tax form
- Documentation that all payroll, employment, and other taxes are filed and paid timely under the consumer's EIN, as outlined in [Section 2.9](#) of this manual

- Documentation of ongoing monitoring of provision of services, including monthly case management activities and annual face-to-face visits, as outlined in [Section 2.9](#) of this manual
- Written care plan and service authorization that document the type of services and quantity of units to be provided
- Documentation of use of EVV in accordance with [13 CSR 70-3.320](#)
- Copies of all correspondence with DSDS, the consumer's physician, other service providers, and other administrative agencies
- Documentation of training provided to the consumer in the skills needed to understand and perform the essential functions of an employer
- Documentation of the consumer's emergency and/or backup plans
- Signed documentation that the consumer has been informed of their rights concerning hearings and consumer responsibilities
- Any pertinent documentation regarding the consumer

Required Documentation

All services provided must be adequately documented in the medical record. For information regarding adequate documentation and adequate medical records, refer to [Section 2.5](#) of this manual.

Providers are required to utilize an EVV system to document services rendered related to the delivery of personal care services for all Medicaid-funded agency and consumer-directed personal care services. Refer to [Section 2.1](#) of this manual for more information regarding EVV.

CDS providers are required to document that all payroll, employment, and other taxes are filed and paid timely under the consumer's EIN.

2.13 Personal Care Services for Children Through 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 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 MHD's~~ Healthy Children and Youth (HCY) Program. Many of the services now available to children under ~~the MHD's~~ HCY Program are

prior authorized by **DHSS BSHCN** through BSHCN's Medically Complex Children and Youth (MCCY) Program. BSHCN's MCCY Program provides service coordination and authorization for medically necessary services for children and youth with medical complexities.

Refer to the **Healthy Children and Youth Provider Manual** for additional information regarding the MHD's HCY Program.

Healthy-Medically Complex Children and Youth Personal Care Authorization

Personal care services for MO HealthNet-eligible children (aged 20 and under) may be authorized by BSHCN through the MCCY Program. 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 PA from BSHCN. Refer to **Section 3.3** of this manual for more information regarding requesting PA for children.

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 (LOC) needs. An example of a personal care need for a child is a child who needs total personal care, or requires extra assistance in bathing, toileting, eating, or other ADLs, 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 MHD. Health plans participating in the MO HealthNet Managed Care program are responsible for arranging, authorizing, and reimbursing for all personal care delivered to enrollees. Refer to **Section 2.16** of this manual for more information on the Managed Care Program.

Healthy-Medically Complex Children and Youth Personal Care 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. This includes children who:

- Require assistance with orthotic bracing, body casts, or casts involving one (1) 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 at four (4) years of age and older (chronic bedwetting and encopresis excluded)
- Have persistent and/or chronic diarrhea, regardless of age
- Have significant central nervous system damage affecting motor control
- Have organically based feeding problems

- Require assistance with ADLs (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 or intellectual disability 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. Refer to the [Home Health Provider Manual](#) or the [Private Duty Nursing Provider Manual](#) for more information.
- 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 DSDS for assessment. In these cases, both the parent and child may be authorized for personal care services. Refer to [Section 3.3](#) of this manual for more information on the Personal Care Plan for Children.

The following are examples of cases where personal care services are appropriate for children. 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 PA.

- A 13-year-old child who uses a wheelchair and needs assistance with breakfast and getting ready for school. The parent must leave for work at 6:30 a.m., too early to get the child ready for the bus. The child is of an age appropriate to get their own breakfast and get dressed for school and has personal care needs.
- A 15-year-old child with a disability who weighs 150 pounds. 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.

- A parent has four (4) children, ages five (5) and under. The five (5)-year old child needs personal care due to a medical condition. The other three (3) children have no medical problems. If the child were an only child, personal care is questionable, despite the disability, because of the availability of the parent. However, the needs of the three (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 years of age, with personal care needs following surgery or an injury

Healthy-Medically Complex Children and Youth Personal Care 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](#) at (800) 392-3738. The care plan must be implemented with some assistance and cooperation of the normal caregiver.

The aide employed by the agency who delivers the personal care service must not be a family member, as defined in [Section 2.1](#) of this manual.

Healthy-Medically Complex Children and Youth Care Plan Development and Registered Nurse Services

The initial care plan for **Children** must be developed by an RN, and the RN must complete the initial evaluation and care plan development in-person. The agency may bill MHD separately for the initial evaluation and care plan development. An evaluation procedure code, which does not require PA, 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. Refer to [Section 5](#) of this manual for procedure codes. 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 BSHCN. Refer to the [BSHCN Regional Map](#) for a directory of BSHCN office locations and contact information. Refer to [Section 3](#) of this manual for information on documentation.

Based on the care plan developed by the RN, the personal care provider submits a request for approval of personal care services to be delivered to the child. The care plan should specify the following:

- Number of hours per week
- Frequency they will be delivered
- Duration of service (how many weeks or months)

Commented [HV1]: I think this should be a bolded subsection with the name change to Medically Complex Children and Youth. The Table of Contents would need to be revised to reflect the change as well. Sorry I missed that on the original review!

Commented [GC2R1]: I am surprised this made it through reviews without being caught, unless I goofed while accepting track changes. Thanks for catching!

Rebecca, I made the name change and spaced this down (it was included at the end of the paragraph above). Can you make this a sub-header to match the one above and update the TOC, please?

- Specific tasks the aide is expected to perform

Personal care is authorized in one (1)-month increments for up to six (6) months per [PA Request](#). Refer to [Section 3](#) of this manual for information on PA.

The provider may request PA 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 also be used 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 PA 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 PA. Refer to [Section 5](#) of this manual for procedure codes.

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. Refer to the [Home Health Provider Manual](#) or the [Private Duty Nursing Provider Manual](#) for more information.

Healthy-Medically Complex Children and Youth Advanced Personal Care Services

Children who require devices and procedures relating to altered body functions may be eligible for APC services [through the MCCY Program](#). The provider agency may request PA from BSHCN. APC services for children must be delivered in accordance with the training and supervisory requirements for APC, as described in [Section 2.7](#) of this manual.

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

2.14 School-Based Individualized Education Plan Direct Services

Personal Care Individualized Education Plan (PC IEP) services are included in the school-based IEP services program for public and charter schools. The program allows for the school district to receive the federal match portion of the funds allocated for certain medical services. Only the services identified in the IEP and up to the amount and duration identified in the IEP will be considered reimbursable.

School-based PC IEP services are medically oriented maintenance of services designed to assist with ADLs during the school day. PC IEP services are medically oriented tasks that are reviewed and approved or certified by a physician as the care necessary to meet a participant's personal, physical needs and thereby enable the participant to attend school. PC IEP services are intended to meet

personal, physical requirements and to meet needs that cannot be met by other resources. PC IEP services must be provided by a qualified individual who is not a member of the participant's family, as defined in [Section 2.1](#) of this manual. The school district must monitor the overall physical care needs of the participant while in the school setting and contact the participant's physician if the participant's condition warrants.

The procedure code for billing PC IEP services in a school setting is T1019 TM. This service is billed in 15-minute increments. All services must be logged and billing is based on the time spent providing a covered service. Observation and waiting time are not covered. Refer to [Section 5](#) of this manual for more information on procedure codes.

To participate in the school-based PC IEP program, the billing provider of the services must be a recognized public school district in the State of Missouri by the Department of Elementary and Secondary Education (DESE). These services are billed by, and reimbursement is made only to the school district. The school district may provide PC IEP services directly or through contract with a personal care provider agency.

If the school district chooses to contract for PC IEP services, the arrangements made by the school district with the actual Personal Care provider agency are between the school district and the provider agency. The personal care provider agency must be a MO HealthNet-enrolled personal care provider and cannot bill directly for MO HealthNet school-based PC IEP services.

For school districts who do not contract with a MO HealthNet-enrolled personal care provider agency, all personal care requirements as set forth in [13 CSR 70-91](#) must be met. A school district providing direct PC IEP services must meet the criteria for a personal care provider agency. The school district must submit a written proposal describing the service delivery system, assure understanding and compliance with the standards of the personal care program, and document the agencies administrative and fiscal ability to provide the services in accordance with these standards. Proposals will be reviewed by qualified medical staff or designees of DSS.

The administrative requirements that must be addressed in the school district's written proposal are as follows. The school district must:

- Maintain bonding, and personal and property liability insurance coverage on all employees involved in delivering PC IEP services
- Have a policy for responding to emergency situations
- Outline how qualified providers will be maintained, including supervisory requirements
- Outline available training and how training documentation will be maintained
- Have a written statement of the participant's Bill of Rights, which shall be given to the parent/guardian at the time the service is initiated. At a minimum, the statement should say the participant has the right to:
 - Be treated with respect and dignity

- Have all personal and medical information kept confidential
- Have direction over the services provided as stated in the IEP
- Know the school district's established grievance procedure and how to make a complaint about the service and receive cooperation to reach a resolution without fear of retaliation
- Receive services without regard to race, creed, color, age, sex, or national origin
- Receive a copy of the Bill of Rights
- Have a written grievance policy which shall be provided to each participant and parent/guardian upon initiation of services. The grievance policy must also include the phone number of the MO HealthNet Constituent Services Unit at (800) 392-2161.
- Report all instances of possible child abuse or neglect to the [Child Abuse/Neglect \(CA/N\) Hotline](#), (800) 392-3738. Any suspected abuse or neglect by a school district employee, including personal care staff, must be reported according to [210, RSMo](#) and could be subject to prosecution. Failure to report by a mandatory reporter (personal care staff would be considered mandatory reports) is a violation of [210.115, RSMo](#) and could be subject to prosecution.
- Maintain the distinction of a public school district with DESE

Whether services are provided directly by the school district or through contact with a personal care agency, the PC IEP services are limited to those providers who meet licensing and supervisory requirements for the PC IEP program.

School-Based Personal Care Aide Requirements

A school-based personal care aide shall meet the following requirements:

- Be at least 18 years of age
- Be able to read, write, and follow directions
- May not be a family member of the participant for whom personal care is to be provided, as defined in [Section 2.1](#) of this manual
- Must be available to provide care in accordance with the care plan, utilizing universal precaution procedures as defined by the CDC
- Prior to the delivery of service, the personal care aid shall receive a copy of the care plan for the participant and be provided with information about the participant to appropriately deliver services to meet the needs of the participant
- Newly employed aides must receive the following orientation and personal care training:

- Twelve (12) hours of orientation training within 30 days of employment, that includes at least two (2) hours' orientation to the school district and the school district protocols for handling emergencies, and a minimum of six (6) hours of training completed prior to participant contact
- Four (4) hours of required training may be waived with adequate documentation in the personal care aide's records that the aide received similar training during the previous 12 months.
- If the personal care aide is a CNA, LPN, or RN, the school district may waive all hours of orientation training, with the exception of the two (2) hours' school district orientation, with adequate documentation placed in the personal care aide's personnel record. The documentation shall include the employee's license or certification number, which must be current and in good standing at the time the training was waived.
- An additional five (5) hours of in-service training annually are required after the first 12 months of employment
 - The school district may waive the required annual five (5) hours of in-service training and require only two (2) hours of refresher training annually, when the personal care aide has been employed by the school district for three (3) years and has completed 15 hours of in-service training that meets the standards set forth in this section
- The school district shall have written documentation of all orientation and in-service training provided which includes, at a minimum, a report of each personal care aide's training that outlines the following:
 - Dates of all training
 - Trainer's name
 - Topics
 - Number of hours
 - Location
 - Date of the first participant contact
 - Aide's signature

If a school district waives an in-service training, the employee's training record shall contain supportive data for the waiver.

School-Based Personal Care Individualized Education Plan Services Supervision

The school district must employ an administrative supervisor of the day-to-day delivery of direct PC IEP services that meets the following requirements:

- Be at least 21 years of age
- Meet at least one (1) of the following criteria before performing the supervisory duties required by these standards:
 - Be an RN who is currently licensed in Missouri
 - Have at least a baccalaureate degree
 - Be an LPN who is currently licensed in Missouri with at least one (1) year of experience with the care of the elderly, or individuals with disabilities or medically complex conditions
 - Have at least two (2) years' experience with the care of the elderly, or individuals with disabilities or medically complex conditions
- Establish, implement, and enforce a policy governing communicable diseases that prohibits contact with participants when the personal care aide has a communicable condition, including colds or flu. Assure that reporting requirements governing communicable diseases, including hepatitis and tuberculosis, as set by the DHSS regulation at [19 CSR 20-20.020](#), are carried out.
- Monitor the provision of services by the personal care aide to assure that services are being delivered in accordance with the care plan
- Make an on-site visit at least annually to evaluate each personal care aide's performance and the adequacy of the care plan, including review of the care plan with the participant and their family. The personal care aide may or may not be present for this evaluation. A written record of the evaluation shall be maintained in the personnel file of the personal care aide.
- Approve, in advance, all changes to the care plan based on supervisory on-site visits, information from the personal care aide, or observation by the RN, or a combination of these, as noted and dated in the participant's file
- Assist in orientation and personal care training for personal care aides
- If the supervisor is not an RN, the school district must have a designated RN currently licensed in Missouri either on staff or employed as a consultant. The RN's responsibilities shall include to initial and review all on-site visit reports made by the administrative supervisor. If supervised by an RN, an LPN, or GN may perform the RN supervisory activities described in this section.

Direct services provided as documented in a IEP are reimbursed on a cost basis at the Federal Financial Participation (FFP) rate. The remainder of the cost is the responsibility of the school district originating the IEP. Claims for all services are to be billed, and interim payments at the FFP rate will be made based on the MHD maximum allowable rate. Direct services are then cost settled in

accordance with the [School-Based IEP Direct Services Cost Settlement Manual](#). The MHD maximum allowable fee for each code can be found on the [Fee Schedule](#).

All services included in the school-based PC IEP program must be billed by the school district. The school district will be considered the billing provider.

The child receiving school-based PC IEP services must be eligible for MO HealthNet coverage for each date a service is rendered for reimbursement to be made. The child must be under the age of 21. All services rendered to a child must be billed under the child's individual MO HealthNet identification number.

The school district and the personal care provider must maintain a copy of the official public school generated IEP and the care plan in the child's record to document the service as an IEP service.

Children enrolled in a MO HealthNet Managed Care health plan receive school-based services that are identifiable in an IEP on a Fee-For-Service (FFS) basis outside the MO HealthNet Managed Care benefit package. For more information about MO HealthNet's Managed Care program, refer to [Section 2.16](#) of this manual.

School-Based Personal Care Individualized Education Plan Provider Enrollment

Each school district interested in billing MHD for school-based PC IEP services must enroll as a MO HealthNet provider. For all enrollment information, go to [MMAC Provider Enrollment website](#).

School districts currently enrolled to provide school-based services who wish to expand to include PC IEP services must contact the MMAC Provider Enrollment Unit to request the PC IEP service be added to the school district's enrollment file. This request can be emailed to MMAC.ProviderEnrollment@dss.mo.gov; faxed to (573) 634-3105 or mailed to:

Missouri Medicaid Audit and Compliance
Attn: Provider Enrollment Unit
PO Box 6500
Jefferson City, MO 65102-6500

If a school district contracts with a personal care agency to provide PC IEP services, the personal care agency must individually enroll with MO HealthNet and meet the requirements outlined in [13 CSR 70-91](#).

Information provided on the MO HealthNet enrollment application must match the information on file with DESE. Refer to [MMAC Provider Enrollment](#) for more information.

School-Based Care Plan

Services are considered school-based when they are included in an IEP as defined by the Individuals with Disabilities Education Act, Part B ([34 CFR 300 and 301](#)). In addition to the IEP, a care plan must be developed and signed by an RN and approved by a physician for a child receiving school-

based PC IEP services. Services must be provided as indicated in the IEP and care plan. A child's care plan must be evaluated at regular intervals.

The care plan must specify the:

- Diagnosis
- Desired outcome
- Nature of the treatment
- Frequency of treatment (number of minutes per day/per week/per month)
- Duration (weeks or months) of services

The child or their family may not be charged for development of the care plan. MHD does not reimburse the school district or personal care providers to participate in IEP meetings or when developing a care plan for a child.

A provider signed care plan must be maintained at the facility where services are performed and must be made available for audit purposes at any time. MHD does not dictate a standardized care plan.

The child's treatment record must also include all components, including adequate documentation as required in [13 CSR 70-3.030](#). Refer to [Section 2.5](#) of this manual for more information.

2.15 Managed Care

Personal care and APC services are covered through the MO HealthNet Managed Care Program. The participant's inclusion or exclusion from participation in one (1) of the MO HealthNet Managed Care health plans may be verified via [eMOMED](#) or by contacting Provider Communications at (573) 751-2896 or toll-free (833) 222-7916.

All services covered by the Managed Care 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 Care health plan which were authorized by the state prior to the participant's enrollment with a health plan must be approved by the health plan.

Refer to the [General Sections Manual](#) for more information on the MO HealthNet Managed Care Program.

2.16 Personal Care Services for Participants Electing Hospice

MO HealthNet covers hospice services for MO HealthNet-eligible persons with a terminal condition whose life expectancy is six (6) months or less. The Hospice Program provides palliative care, rather than active treatment.

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 which hospice provider is providing care.

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, the case manager should be notified. Hospice participants are identified while verifying participant eligibility via [eMOMED](#) or by contacting Provider Communications at (573) 751-2896 or toll-free (833) 222-7916.

Refer to the [Hospice Provider Manual](#) for more information on covered hospice benefits.

2.17 Provider Reassessments

HCBS providers have the option to partner with DSDS as provider re-assessors. Provider re-assessors can complete their participants' reassessments and gather the necessary information for DSDS to determine participants' continued eligibility for HCBS. If a provider chooses not to participate in the reassessment and care planning process, DSDS or a value-based re-assessor designee will reassess the participant.

If a provider chooses to assist with the reassessment of participants, the following criteria must be met:

- Providers must complete a reassessment packet with MMAC and be approved by MMAC as a provider re-assessor in order to complete and bill for the completed reassessments.
- Providers are authorized to complete and bill for reassessments only for those participants who appear on their assigned queue in the electronic case record review system, which assigns a monthly list of participants requiring reassessment to each qualified provider. Reimbursement for a reassessment is limited to one (1) payment per participant.
 - Providers must ensure that all reassessments are completed by a provider staff that has completed the [DHSS online training modules](#) or train the trainer class and passed the provider re-assessor exam.
- Providers must ensure all appropriate documentation is entered in the participant's electronic case record to verify that the reassessment was completed timely by a certified provider re-assessor.

DHSS maintains a list of qualified provider re-assessors.

Refer to [MMAC Provider Enrollment](#) for more information on enrolling as a provider re-assessor.

2.18 Accrued Units

A unit of personal care service is 15 minutes of direct service to the participant.

Personal care providers (under either model) may bill up to one (1) full month of service on one (1) 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 15-minute units, at the end of the day, week or month, as long as care delivery is consistent with the written care plan.

Providers must monitor accrued minutes and determine when they reach a full unit, in accordance with 13 CSR 70-91. When submitting accrued minutes visits to the EVV Aggregator Solution (EAS), providers and vendors must adhere to the following requirements:

- Use reason code 280 (Accrued Minutes Visit)
- Submit accrued minutes visits for the month in which the minutes were accrued; minutes do not carry over from month to month
- Submit no more than one (1) accrued minutes visit per day, per participant, per procedure code/modifier
- Duration of the visit must be divisible by 15 (e.g., 30 minutes, 45 minutes). There is no unit restriction
- Visits must include all required data elements to be in a verified status
 - The caregiver submitted on the accrued minutes visit must be a caregiver associated with the participant DCN
 - Start and end time for any time period may be used, as long as it is divisible by 15 and does not have the same start and end times as an existing visit for the same service on the same date
 - For visits requiring tasks, a new task titled "Accrued Minutes Visit" (task code 0280) must be submitted when reason code 280 is used; no other tasks are required
 - For visits requiring a memo, providers may use a default memo "This is an accrued minutes visit," when reason code 280 is used

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 a.m. to 11:40 a.m. on June 1, then provides care from 10:00 a.m. to 12:10 p.m. on June 4. Six (6) units of service are billed for June 1, and nine (9) units of service are billed on June 4.
- When billing multiple dates of service on one (1) 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. $620/15=41.33$ units. Bill for 41 whole units of service.

- When billing multiple dates of service on one (1) detail line of a claim, dates during which the client is in a hospital, in a nursing home facility, visiting relatives or is ineligible should not be included in the range of dates.
- When billing multiple dates of service on one (1) detail line of a claim, do not bill for dates of service falling in two (2) separate calendar months.

Section 3: Special Documentation Requirements

3.1 Prior Authorization

All services covered by the Title XIX Medicaid Personal Care Program, whether delivered via agency or consumer-directed model, must be prior authorized by a Missouri State Agency or its designee before services may be delivered. The specific state agency responsible for prior authorizing any given personal care service is dependent upon the MO HealthNet Program under which the participant is potentially eligible to receive services. Each state agency utilizes assessment and authorization processes unique to their program.

Clients may not always clearly fall under one (1) of the below described state agencies' case management programs; however, this basic information is provided as a guide.

- If a participant that is aged (65 years of age or older), or 18 years of age or older and has a disability, the authorizing state agency is the Department of Health and Senior Services (DHSS) Division of Senior and Disability Services (DSDS).
- For children under 21 years of age, the involved state agency is DHSS Bureau of Special Health Care Needs (BSHCN).

The effective date for the prior authorization (PA) cannot precede the completion date of the assessment. The end date for the PA shall not exceed the last full month within 365 days from the completion date of the assessment.

If a participant loses MO HealthNet eligibility or coverage during an authorized period of time, services are not reimbursed for the ineligible dates, the posted PA notwithstanding. Refer to the [General Sections Manual](#) for details about participant eligibility.

Providers should ensure that the participant's name and identification number on the PA match the information on the participant's MO HealthNet ID card, and that the PA contains the provider's correct name for the service to be provided. If any of these items are incorrect, the provider should immediately contact DHSS or its designee to initiate a correction.

Prior Authorization in the Participant Case Record

All services authorized by DSDS or its designee are prior authorized in the participant's electronic case record. Home and Community Based Services (HCBS) providers can receive guidance on the electronic case record system, Fusion, by referring to the [HCBS Fusion Provider End User Guide](#).

A participant's care plan may be accessed in the participant's electronic case record. This record provides specific information pertaining to the participant's case, such as authorized HCBS services, authorized time per each task, the total units per month, and the PA number assigned to the service.

Each care plan has a specific PA number assigned to aid in identification. A copy of the initial and all subsequent plans of care are provided to the participant. An initial copy is mailed to the physician.

Providers have access to scanned documents (e.g., [Participant Choice Statement](#)), case notes, and assessments within the participant's electronic case record.

All documents become a part of the fiscal and medical records, which must be retained to document services billed to the MO HealthNet Division (MHD). Any document used to bill MHD for services rendered (e.g., care plan/authorization, documentation of services delivered, etc.), must be retained and available for inspection.

Refer to [Section 2.5](#) of this manual for more information on the participant case record. Refer to the [General Sections Manual](#) for further information on retention of records requirements.

3.2 Provider Supervisory Monitoring

Supervisors are required to monitor the provision of services by the personal care aide to ensure that services are being delivered in accordance with the care plan. This should be primarily in the form of an at least monthly review and comparison of the service participant/aide's log of provided services with the care plan. Documentation, including the reason, must be kept on authorized services and units not delivered.

Refer to [Section 2.5](#) of this manual for more information on record requirements.

3.3 Requesting Prior Authorization for Children

A personal care provider may receive a referral from a hospital discharge planner, a family member, a physician, or other source, requesting personal care services on behalf of a child under the age of 21. The personal care provider must take the following steps to request approval for service delivery to a child:

- A care plan must be developed listing the duties of the personal care aide, duties of the nurse (if required) and the duration and frequency of the visits. This may be done by the provider agency's registered nurse (RN). The care plan for children is not a standard form. The [Personal Care Plan for Children](#) may be used as is, or the provider may develop their own form as long as it contains sufficient information about the personal care services and tasks required, and the physician's signature and date.

- Physician approval, which documents the child's medical condition and the need for personal care services, must be obtained. Physicians may approve personal care services by:
 - Writing an order or prescription for personal care, specifying the medical condition requiring the care
 - Signing a Physician Certification. The Physician Certification is not a standard form. The Physician Certification of Need for Personal Care Services may be used as is, or the provider may use another format, such as the physician signature on the Individualized Treatment Plan (ITP). Whichever format is used, it must contain sufficient information verifying the medical diagnosis and the care plan.
 - Signing a care plan, or another form similar to the [Personal Care Plan for Children](#).

Review and Determination of Prior Authorization for Children

Upon receipt of all required documentation, including the care plan and physician approval, BSHCN reviews the request for services and approves or denies the request as appropriate. Based on that determination, BSHCN completes the [Prior Authorization Request](#) and forwards it to the fiscal agent for processing.

The fiscal agent returns a Missouri Medicaid Authorization Determination to the provider. The Missouri Medicaid Authorization Determination serves as provider notification of PA approvals or denials.

Requesting a Change to an Approved Prior Authorization

If the personal care provider agency determines that it is necessary to request a change to an approved Prior Authorization Request, agency staff must submit this request through the BSHCN regional office serving the county of the child's residence. Refer to the [BSHCN Regional Map](#) for a directory of BSHCN office locations and contact information.

Reauthorizations

Reauthorization requests should be submitted to BSHCN during the last month of the current authorization period to allow time for review and approval. Follow the same steps as listed above to request reauthorizations.

The reauthorizations should document progress or changes in the child's medical needs. The documentation should support the continuation of service or explain why changes in level of service are planned.

3.4 Home and Community-Based Services Referral

Referrals for HCBS can be made to DSDS by submitting the [Online HCBS Referral Form](#). Submitting referrals online allows for increased efficiency with processing. If the referral cannot be

submitted online, providers may complete the [Home and Community Based Services Referral](#) and email the form to HCBSCallCenterReferrals@health.mo.gov.

NOTE: The HCBS Intake and Person-Centered Care Plan (PCCP) Customer Service Contact Center phone lines are reserved for participants and their supports who have no other means to initiate communication with DSDS. Providers and professional community partners must initiate HCBS referrals and requests electronically. Refer to the [Communicating with HCBS Intake and PCCP Quick Guide](#) for more information.

3.5 Home and Community-Based Services Participant Choice Statement

The [Participant Choice Statement](#) is used by DSDS and allows documentation of the participant's involvement in determining the care plan by including the participant's acknowledgment of their:

- Right to participate in the development of the care plan
- Right to have anyone involved in the development of the care plan
- Right to choose and receive HCBS or nursing facility care
- Loss of services due to discriminatory behavior regarding service delivery
- Expectations and responsibilities
- Right to choose a qualified home and community-based provider
- Need to notify the [Missouri Adult Abuse and Neglect Hotline](#) to report abuse, neglect, or exploitation
- Need to notify the DSDS [PCCP Team](#) of any problems concerning service delivery as well as changes in health, formal and informal supports, satisfaction with the services provided, and/or functioning status that might require care plan adjustment

The [Participant Choice Statement](#) is completed by DSDS or its designee upon initial assessment and any subsequent assessment. DSDS or its designee reviews the information covered on the form with the participant or their authorized representative and ensures the participant's understanding of the information and obtains the signature of agreement. The document is retained in the participant's electronic case record. A copy is provided to the participant.

3.6 Authorization of Care Plan Changes

When an existing care plan requires a decrease in authorized services, DSDS staff will enter the effective date of change in the participant's electronic case record as the first day of the first month following the date the change is made. This change applies regardless of whether the need for decrease is identified in mid-authorization or at reassessment. This also applies when there is a need for a decrease due to cost cap adjustment.

If there are no changes required to the care plan upon reassessment, DSDS staff will enter the effective date of change in the participant's electronic case record as the first day of the first month following the date of reassessment.

While all efforts will be made to avoid mid-month care plan changes as described above, certain circumstances may require the authorization change to be made during the month. In these circumstances, providers shall not bill more units than the higher of the two (2) authorizations for the month, and providers shall not bill for units not delivered. Units billed in excess of the higher of the two (2) authorizations or for services not delivered are subject to recoupment.

DSDS will continue to follow current care plan protocol when a need for an increase is identified during reassessment or following a request for a care plan change. This means the effective date may fall during the middle of the month. When this happens, two (2) authorizations are active at the same time for that month. However, one (1) authorization ends on the date prior to the increase and one (1) authorization begins on the date of the increase through the end of that authorization period. Again, providers must not bill more than the total units of the higher of the two (2) care plan authorizations, and the provider shall not bill for units not delivered. Units billed in excess of the higher of the two (2) authorizations or for services not delivered are subject to recoupment.

Section 4: Billing Instructions

4.1 Electronic Data Interchange

Providers exchanging electronic transactions with the MO HealthNet Division (MHD) should access the [ASC X12 Implementation Guides](#), adopted under the Health Insurance Portability and Accountability Act (HIPAA). For Missouri specific information, including connection methods, the biller's responsibilities, forms to be completed prior to submitting electronic information, as well as supplemental information, reference the [X12 Version v5010](#) and [NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guides](#).

4.2 Electronic Claim Submission

Providers may submit claims via [eMOMED](#). For access to eMOMED, providers are required to register. Each individual provider, billing staff, or billing service/clearinghouse representative must be approved to access eMOMED.

The following claim types can be used in online applications: Medical (NSF), Inpatient and Outpatient (UB-04), Dental, Nursing Home and Pharmacy. For convenience, some of the input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

Refer to the [General Sections Manual](#) for more information on eMOMED and claim submission.

4.3 Unit of Service

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

Personal care providers (both in-home agency and Consumer-Directed Services (CDS)) may bill up to one (1) full month of service on one (1) detail line 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 a.m. to 11:40 a.m. on June 1, then provides care from 10:00 a.m. to 12:10 p.m. on June 4. Six (6) units of service are billed for June 1, and nine (9) units of service are billed on June 4. Units of the same type of services may accrue, but units of different types of services may not be combined.

4.4 CMS-1500 Claim Form

The CMS-1500 claim form is always used to bill MHD for personal care services unless a provider bills those services electronically. Instructions on how to complete the CMS-1500 claim form are on the following pages.

The [CMS-1500 claim form](#) should be typed or legibly printed. It may be duplicated if the copy is legible. MHD claims should be mailed to:

Wipro Infocrossing
P.O. Box 5600
Jefferson City, MO 65102

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two (2) asterisks (**) beside the field number indicate a field is required in specific situations.

Field Number	Field Name	Instructions for Completion
1	Type of Health Insurance Coverage	Show type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed check the Medicare box, if a MHD claim is being filed check the Medicaid Box and if the patient has both Medicare and MO HealthNet, check both boxes.

Field Number	Field Name	Instructions for Completion
1a*	Insured's ID Number	Enter the patient's eight (8)-digit MO HealthNet or MO HealthNet Managed Care ID number (DCN) as shown on the patient's ID card
2*	Patient's Name	Enter last name, first name, middle initial in that order as it appears on the ID card
3	Patient's Birth Date Sex	Enter month, day, and year of birth. Mark appropriate box
4**	Insured's Name	If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete Fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5	Patient's Address	Enter address and telephone number if available
6**	Patient's Relationship to Insured	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7**	Insured's Address	Enter the primary policyholder's address; enter policyholder's telephone number, if available. If no private insurance is involved, leave blank.
8	Patient Status	Not required
9**	Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. Refer to the General Sections Manual for further Third Party Liability (TPL) information.

Field Number	Field Name	Instructions for Completion
9a**	Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. Refer to the General Sections Manual for further TPL information.
9b**	Reserved for NUCC Use	Leave blank
9c**	Reserved for NUCC Use	Leave blank
9d**	Insurance Plan Name or Program Name	Enter the other insured's insurance plan or program name. If the insurance plan denied payment for the service provided, attach valid denial from the insurance plan. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. Refer to the General Sections Manual for further TPL information.
10a-10c**	Is Condition Related to:	If services on the claim are related to patient's employment, auto accident or other accident, mark the appropriate box. If the services are not related to an accident, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. Refer to the General Sections Manual for further TPL information.
10d	Claim Codes (Designated by NUCC)	Leave blank

Field Number	Field Name	Instructions for Completion
11**	Insured's Policy or Group Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. Refer to the General Sections Manual for further TPL information.
11a**	Insured's Date of Birth, Sex	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. Refer to the General Sections Manual for further TPL information.
11b**	Other Claim ID (Designated by NUCC)	Enter the 'Other Claim ID.' Applicable claim identifiers are designated by the NUCC.
11c**	Insurance Plan Name	Enter the primary policyholder's insurance plan name If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. Refer to the General Sections Manual for further TPL information.

Field Number	Field Name	Instructions for Completion
11d**	Other Health Plan	Indicate whether the patient has a secondary health insurance plan; if so, complete Fields 9-9d with the secondary insurance information. If no private insurance is involved, leave blank. If the insurance plan denied payment for the service provided, attach valid denial from the insurance plan. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny. Refer to the General Sections Manual for further TPL information.
12	Patient's Signature	Leave blank
13**	Insured's Signature	This field should be completed only when the participant has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14	Date of Current Illness, Injury, or Pregnancy (LMP)	Leave blank
15	Date Same/Similar Illness	Leave blank
16	Dates Patient Unable to Work	Leave blank
17**	Name of Referring Provider or Other Source	Enter the name of the referring provider or other source. If multiple providers are involved, enter one (1) provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider

Field Number	Field Name	Instructions for Completion
17a**	Other ID #	Enter the Provider Taxonomy qualifier ZZ in the first shaded area if the provider reported in Field 17b is required to report a Provider Taxonomy Code to MHD. Enter the corresponding 10-digit Provider Taxonomy Code in the second shaded area for the provider reported in Field 17b.
17b**	NPI	Enter the National Provider Identifier (NPI) of referring, ordering, or supervising provider
18	Hospitalization Dates	Leave blank
19	Reserved for Local Use	Providers may use this field for additional remarks/descriptions
20	Lab Work Performed Outside Office	Leave blank
21*	Diagnosis	Enter the complete current International Classification of Diseases-Clinical Modification (ICD-CM) diagnosis code(s). Enter the primary diagnosis under No. 1, the secondary diagnosis under No. 2, etc.
22**	MO HealthNet Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim under original Ref. NO. or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23	Prior Authorization Number	Leave blank

Field Number	Field Name	Instructions for Completion
24a*	Date of Service	Enter the date of service under 'from' in month/day/year format, using six (6)-digit format in the unshaded area of the field. All line items must have a from date. The six (6) services lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the service lines are shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.
24b*	Place of Service	Enter the appropriate place of service (POS) code in the unshaded area of the field. For personal care, enter 12 (Home). Refer to Section 4.6 of this manual for more information.
24c	EMG-Emergency	Leave blank
24d*	Procedure Code	Enter the appropriate Current Procedure Terminology (CPT) code or Health Care Procedure Coding System (HCPCS) code and applicable modifier(s), if any, corresponding to the service rendered in the unshaded area of the field. (Field 19 may be used for remarks or descriptions.) Refer to Section 5 of this manual for applicable procedure codes.
24e*	Diagnosis Pointer	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from Field 21 in the unshaded area of the field
24f*	Charges	Enter the provider's charge for each line item in the unshaded area of the field. This should be the total charge if multiple days or units are shown.

Field Number	Field Name	Instructions for Completion
24g*	Days or Units	Enter the number of days or units of service provided for each detail line in the unshaded area of the field. The system automatically populates a '1' if the field is left blank. A unit of service equals 15 minutes. Refer to Section 4.3 of this manual for more information.
24h**	EPSDT/Family Planning	Enter the following depending on the service: • HCY screening service or referral, enter 'E' • Family planning related, enter 'F' • Both HCY and Family Planning, enter 'B'
24i**	ID Qualifier	Enter the Provider Taxonomy qualifier ZZ in the shaded area if the rendering provider is required to report a Provider Taxonomy Code to MHD. A provider taxonomy code must be reported if providers have one (1) NPI for multiple legacy MO HealthNet provider numbers.
24j**	Rendering Provider ID	If the Provider Taxonomy qualifier was reported in 24i, enter the corresponding 10-digit Provider Taxonomy Code in the shaded area. Enter the 10-digit NPI number of the individual rendering the service in the unshaded area.
25	SS #/Federal Tax ID	Leave blank
26	Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here
27	Assignment	Not required on MHD claims
28*	Total Charge	Enter the sum of the line item charges

Field Number	Field Name	Instructions for Completion
29	Amount Paid	Enter the total amount received by all other insurance resources. Previous MHD payments, Medicare payments, cost sharing, and copay amounts are not to be entered in this field.
30	Balance Due	Enter the difference between the total charge (Field 28) and the insurance amount paid (Field 29)
31	Signature of Physician or Supplier	Not required
32**	Name and Address of Facility	If services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office. Personal care services are in POS 12 (Home). Refer to Section 4.6 of this manual for more information.
32a**	NPI#	Enter the 10-digit NPI number of the service facility location reported in Field 32
32b**	Other ID#	Enter the Provider Taxonomy qualifier ZZ and corresponding 10-digit Provider Taxonomy code for NPI reported in field 32a if the provider is required to report a Provider Taxonomy Code to MHD. Do not enter a space, hyphen or other separator between the qualifier and code. A provider taxonomy code must be reported if providers have one (1) NPI for multiple legacy MO HealthNet provider numbers.
33*	Provider Name/Number/Address	Enter the provider's name, phone number, and address
33a**	NPI#	Enter the NPI number of the billing provider in Field 33

Field Number	Field Name	Instructions for Completion
33b**	Other ID#	Enter Provider Taxonomy qualifier ZZ and corresponding 10-digit Provider Taxonomy code for the NPI reported in Field 33a if the provider is required to report a Provider Taxonomy Code to MHD. Do not enter a space, hyphen or other separator between the qualifier and code.

* These fields are mandatory on all CMS-1500 claim forms.

** These fields are mandatory only in specific situations, as described.

4.5 Resubmission of Claims

Any line item on a claim that resulted in a zero (0) payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny must be corrected before resubmitting the claim. The provider may resubmit via [eMOMED](#) or on a [CMS-1500 claim form](#).

In certain situations, providers may receive an underpayment on a submitted claim. When a claim is paid, whether in full or in part, the resubmission of the claim may result in its denial as a duplicate. In cases where the whole claim (zero (0) payment) has been previously denied, the provider may then resubmit with the appropriate corrections. The above applies to overpayments as well. Refer to the [General Sections Manual](#) for specific information regarding adjustments.

4.6 Place of Service Codes

The only acceptable place of service (POS) for personal care services is 12 (Home). The licensed Residential Care Facility (RCF)/Assisted Living Facility (ALF) is considered the participant's home for the purpose of providing MO HealthNet personal care services; therefore, the POS code for services delivered in an RCF/ALF is also 12.

Code	Description	Definition
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence

Refer to the [General Sections Manual](#) for more information on POS codes.

4.7 Insurance Coverage Codes

Type of insurance coverage codes identified on [eMOMED](#), may be identified by referring to the [General Sections Manual](#) or contacting Provider Communications at (573) 751-2896 or toll-free (833) 222-7916.

While providers are verifying the patient's eligibility, they can also obtain the Third Party Liability (TPL) information contained on the MO HealthNet participant file.

Participants must always be asked if they have third party insurance regardless of the TPL information given by [eMOMED](#) or Provider Communications. It is the provider's responsibility to obtain from the participant the name and address of the insurance company, the policy number, and the type of coverage. Refer to the [General Sections Manual](#) for more information on TPL.

4.8 Diagnosis Codes

The diagnosis code must be entered on the claim form exactly as it appears in the applicable International Classification of Diseases-Clinical Modification (ICD-CM). The appropriate code(s) may be up to seven (7) digits, depending upon the patient's diagnosis and applicable ICD code version.

Section 5: Procedure Codes

Procedure codes used by the MO HealthNet Division (MHD) are identified as Health Care Procedure Coding System (HCPCS) codes. The HCPCS is divided into two (2) subsystems, referred to as Level I and Level II. Level I is comprised of Current Procedural Terminology (CPT) codes that are used to identify medical services and procedures furnished by physicians and other health care professionals. Level II is comprised of the HCPCS National Level II codes that are used primarily to identify products, supplies and services not included in the CPT codes.

Reference materials regarding the HCPCS CPT may be obtained through the [American Medical Association](#).

This section lists the appropriate procedure codes for the billing of personal care services.

5.1 Services Authorized by Division of Senior and Disability Services

The following codes are for services authorized by the Division of Senior and Disability Services (DSDS).

Procedure Code	Description	Service Unit
T1001	Authorized Nurse Visit	Per visit
T1001 U3	Authorized Nurse Visit in RCF/ALF	Per visit
T1019	Personal Care	15 minutes
T1019 TF	Advanced Personal Care	15 minutes
T1019 U2	CDS Personal Care	15 minutes
T1019 U3	Personal Care in RCF/ALF	15 minutes

Procedure Code	Description	Service Unit
T1019 U3TF	Advanced Personal Care in RCF/ALF	15 minutes
T1028 TS	Participant Reassessments	One (1) per year

5.2 Services Authorized for Children by the Bureau of Special Health Care Needs

The following codes are valid only for MO HealthNet participants aged 0-20 years, for services under the Healthy Children and Youth (HCY) Program. Refer to the [HCY Provider Manual](#) for more information.

Procedure Code	Description	Service Unit
T1001 EP	Authorized Nurse Visit	Per visit
T1019 EP	Personal Care	15 minutes
T1019 TFEP	Advanced Personal Care	15 minutes

The following code requires no prior authorization and is restricted to participants under the age of 21. Two (2) visits may be billed per participant, per agency, per rolling year.

Procedure Code	Description	Service Unit
T1001 TDEP	Registered Nurse (RN) Evaluation Visit for Personal Care through HCY	Per visit

A rolling year is client specific. For example, if a client's first date of service is April 15, 2026, then two (2) evaluation visits could be billed between April 15, 2026, and April 14, 2027, by one (1) provider.

5.3 School-Based Individualized Education Plan Direct Services

The following procedure code is used for billing Personal Care Individualized Education Plan (PC IEP) services in a school setting. Refer to [Section 2.14](#) of this manual for more information.

Procedure Code	Description	Service Unit
T1019 TM	Personal Care for an IEP	15 minutes