

Home and Community Based Services

Policy Clarification Questions (PCQ) and Answers

The purpose of this document is to clarify policy and apply it situationally. This is not intended to create new policy. The contents are subject to change based on revisions to statutes, regulations or Centers for Medicare and Medicaid Services (CMS) requirements. Each question and answer is phrased and categorized based on how it was presented to the Division of Senior and Disability Services (DSDS) and may be applicable to other sections as well.

Please note: Guidance released during the COVID-19 emergency period supersedes any conflicting information found within this document.

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HCBS Policy Clarification Questions

Assisted Living Facility/Residential Care Facility Personal Care

1. If a participant at a Residential Care Facility/Assisted Living Facility (RCF/ALF) requires a continuous positive airway pressure (CPAP) machine and/or an oxygen concentrator and is unable to place the nose piece/mask correctly without assistance, can this task be authorized?
 - A. This would be an allowable authorized task under dressing/grooming due to extra time to work around cords and ensure the nose pieces/mask stay in place.
2. If a participant in a Residential Care Facility/Assisted Living Facility (RCF/ALF) requires meal prep time for specialized diets (i.e. diabetic meals), how should time be authorized?
 - A. During the development of a person centered care plan (PCCP), staff should authorize the appropriate number of units to reflect the time it takes to prepare the specialized diet. Per Policy 3.20, Personal Care Services in a Residential Care Facility/Assisted Living Facility are authorized to eligible residents when the needs of the resident exceed the minimum obligations of the facility pursuant to the respective licensure requirement. Provider billing should reflect time spent delivering the task.
3. If a participant in a Residential Care Facility/Assisted Living Facility (RCF/ALF) has a physician's order to check blood pressure and pulse twice daily, can this task be authorized?
 - A. Checking blood pressure and pulse are not authorized tasks under the Personal Care or Advanced Personal Care program. This task is one that would fall under the protective oversight of the Residential Care Facility/Assisted Living Facility.
4. Can Nurse Visits be authorized for a participant in a Residential Care Facility/Assisted Living Facility (RCF/ALF) who is in need of Diabetic Nail Care if the participant has been diagnosed in the past with diabetes, but is not currently on a diabetic diet?
 - A. Any supporting documentation to determine the participant's current diagnosis of diabetes (diagnosis codes in CyberAccess, prescription, verbal conversation with doctor, observation of insulin during assessment) would support the authorization of Diabetic Nail Care. Not all diabetics follow a diabetic diet.
5. A Residential Care Facility/Assisted Living Facility (RCF/ALF) is requesting time to apply prescription eye drops and prescription ointment to a participant's eye. The participant is able to administer their own drops; however, they require assistance to steady the hand. Is this task reimbursable?
 - A. This can be authorized as non-injectable medications under Advanced Personal Care in a RCF/ALF.
6. Are staff members of a Residential Care Facility/Assisted Living Facility (RCF/ALF) allowed to be recognized as guardians of a resident if their actual guardians request to give the facility the right to make some basic health decisions concerning the resident?

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- A. Guardian-signed forms that indicate the facility staff can make basic health decisions on behalf of the resident are not accepted. The guardian is appointed through the court system and DSDS will recognize the guardian that was approved/appointed by the judge only. However, it is protocol that DSDS consult facility staff when developing the person centered care plan for a participant.
7. Can Personal Care (PC) and Advanced Personal Care (APC) be authorized to an individual who resides within a licensed group home?
- A. State plan personal care services, as authorized by DSDS, can only be authorized to an individual in their own home or a licensed Residential Care Facility/Assisted Living Facility (RCF/ALF). A licensed group home does not fit the definition of “their own home” and therefore the individual would not be eligible for in-home services. This is based on the Code of State Regulation, [13 CSR 70-91.010](#) Personal Care Program (1)(B)1.
8. If a participant resides in a Residential Care Facility/Assisted Living Facility (RCF/ALF) and requires blood sugar monitoring for diabetes, can the task be authorized?
- A. This is an allowable Advanced Personal Care (APC) task under non-injectable medications. The aide can help the participant complete the task by steadying the participant’s hand in order for the participant to apply the skin stick, but the aide cannot complete the skin stick independently. The aide can also assist in reading the levels if needed. The person centered care plan would remain the same if the participant had the same needs upon reassessment.
9. If a participant requires assistance with a nebulizer and resides within a Residential Care Facility/Assisted Living Facility (RCF/ALF), can this task be authorized?
- A. This would be an allowable authorized task under Basic Personal Care Self-Administration of Medications. As noted in [Policy 3.20](#), taking medications to a participant, including medication for nebulizers, so that the participant may self-administer their medications is considered an appropriate authorization of units for that purpose. The aide may carry and setup the equipment, open the medication packaging, place the medication into the nebulizer (prepackaged only), steady the participant’s hand during the treatment and clean the equipment as needed. Starting the machine **must** be performed by the participant as it constitutes administration of medication. The same parameters apply regardless of service setting.
10. If a participant within a Residential Care Facility/Assisted Living Facility (RCF/ALF) has physician orders to administer injections, can Nurse Visits be authorized for this participant?
- A. The protocol for authorizing nurse visits to residents of a RCF/ALF is if a potential participant was admitted into the facility with orders from a physician to administer an injection, that participant would not be eligible for an authorized nurse visit. However, if a current resident did not have an admission order for injections and there were changes to their care needs which resulted in the participant’s physician ordering an injection, the participant may be eligible for an authorized nurse visit. If a

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participant has an authorization in place for a nurse visit and moves to another RCF/ALF, the authorization should remain the same unless the needs have changed.

11. If a participant in a Residential Care Facility/Assisted Living Facility (RCF/ALF) has been advised by their physician to avoid concentrated sweets due to their diabetic condition, but has no other dietary restrictions, can meal prep time be authorized?
 - A. Yes, dietary time should be authorized any time the facility goes above and beyond what they would normally prepare due to a participant's health condition.
12. Can nail care for participants who reside within a Residential Care Facility/Assisted Living Facility (RCF/ALF) be authorized if they are not able to trim their own nails?
 - A. Yes, if the participant is unable to trim their own nails, 15 minutes, once per week can be authorized under dressing/grooming.

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Advanced Personal Care

1. Is it required that a Registered Nurse (RN) assists with the Advanced Personal Care (APC) assessment with state staff during the initial assessment for eligibility conducted by state staff?
 - A. No, this is not required. Regulation, specifically [13 CSR 70-91.010](#) Personal Care Program (5)(D) in part says APC Plans must be developed by the provider RN in collaboration with the state. Two Nurse Visits are authorized during the first month of services for the training of the APC aide and evaluation of the adequacy of the service plan. The provider nurse communicates with DSDS during this process if the care plan is not effectively meeting the needs of the participant.

2. Are Advanced Personal Care (APC) aides authorized to apply participants' pain patches?
 - A. The administration of pain patches is considered administration of medication. Therefore, placement or removal of the patch is not an allowable APC task. This would be considered a nursing level task and could be performed during a regularly scheduled nurse visit. The APC aide can however provide assistance by opening the packaging, peeling the backing, or steadying the hand during the application. This assistance would be authorized under APC self-administration of a medication.

3. Are Advanced Personal Care (APC) aides authorized to apply and remove compression dressings, such as medical support stockings/hosiery even if a participant is not able to remove them on their own?
 - A. This is dependent upon the compression levels – Over the Counter (15-20mmHg), Class I (20-30mmHg), Class II (30-40mmHg), and Class III (40-50mmHg). Over the counter or Class I rated medical support stocking can be authorized as basic personal care under dressing/grooming. A Class II can be authorized as advanced personal care (if the participant can remove the item on their own) under aseptic dressing. A Class III (life supporting or life sustaining device or for use which is of substantial importance in preventing impairment of human health, or if the device presents unreasonable risk of illness or injury) cannot be authorized. ACE wraps and compression hose/stockings need to be placed on participant under APC, with the understanding that the participant can remove them on their own accord for emergency needs of swelling, bleeding, pain or drainage. This can also be done by a family member or friend of the participant in case of an emergency if the family member or friend is with the participant for majority of the time. There should be additional nurse visits scheduled in the first month of any new APC task so the nurse can properly train/guide the APC aide.

4. If a participant needs assistance placing and removing a pneumatic compression device (an inflatable sleeve, glove, or boot designed to improve circulation), can this be authorized under APC?
 - A. This is an allowable Advanced Personal Care task under aseptic dressing, as long as the participant can deflate/remove the devices on their own accord for emergency needs of swelling, bleeding, pain or drainage. This can also be done by a family member or friend of the participant in case of an emergency

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if the family member or friend is with the participant for majority of the time. There should be additional nurse visits scheduled in the first month of any new APC task so the nurse can properly train/guide the APC aide.

5. Under ostomy hygiene, is an Advanced Personal Care (APC) aide allowed to change the ostomy wafer when cleaning the bag?
 - A. Changing the wafer is a component of changing a colostomy bag process and appropriate hygiene, thus the APC Aide should change the wafer as well.

6. If a participant has a stoma and requires over the counter laxatives, can the Advanced Personal Care (APC) aide mix the laxative with water and administer it via the stoma?
 - A. Due to the presence of the stoma, the administration of the laxative and water is not a covered service and cannot be authorized through Personal Care (PC) or APC. This would be considered a nursing level task, and could be performed during a regularly scheduled nurse visit. Authorization of nurse visits are limited to 26 visits in a 6 month period.

7. Are Advanced Personal Care (APC) aides authorized to perform a Malone Integrated Continence Enema (MACE), which is an enema inserted through a port within the abdomen?
 - A. This can be authorized as an APC task under bowel program once the stoma site is well healed.

8. Under ostomy hygiene, are Advanced Personal Care (APC) aides allowed to suction out tracheostomies?
 - A. No suctioning of any kind is an allowable task under APC. It must be completed by a nurse or trained family member.

9. If a participant has an oxygen concentrator, can the aide clean the tubing and add water to the concentrator, as well as clean the filter?
 - A. This is considered Basic Personal Care under self-administration of medications; the aide is allowed to assist with cleaning the tubing, filter, and adding water to the machine.

10. Are Advanced Personal Care (APC) aides authorized to clean urinary catheters and change the bag?
 - A. Changing the bag, as well as soap and water hygiene around the insertion site, are allowable APC tasks under catheter hygiene.

11. Are Advanced Personal Care (APC) aides allowed to apply Transcutaneous Electrical Nerve Stimulation (TENS) unit electrodes to a participant if it is in a location the participant is not able to do so by himself/herself?

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- A. The placement of TENS unit electrodes is an approved APC task under non-injectable medications; however the participant must turn the machine on and off himself/herself.
12. If a participant uses a gait belt for transferring from bed to wheelchair and vice versa and the aide uses the belt to assist with the process, is this an allowable Advanced Personal Care (APC) task?
- A. Gait belts are approved to use as a transfer device for APC services. Gait belts may also be utilized at the provider's discretion for the purpose of mobility assistance (Basic Personal Care).
13. If a participant requires a physician ordered orthotic brace, can an Advanced Personal Care (APC) aide assist in removing and replacing the brace?
- A. This is an allowable APC task under aseptic dressing as long as the participant can remove the orthotic on their own accord for emergency needs of swelling, pain, etc. This can also be done by a family member or friend of the participant in case of an emergency if the family member or friend is with the participant for majority of the time. There should be additional nurse visits scheduled in the first month of any new APC task so the nurse can properly train/guide the APC aide.
14. With regards to the bowel program, if a participant requires assistance such as sphincter stimulation or pre-packaged enemas to prevent or assist with fecal impaction, is it ok to authorize additional time for the bowel program under Advanced Personal Care (APC)?
- A. Determining the time needed to ensure a participant's needs are being met is based on the individual needs of the participant. The units should be authorized based on time necessary to complete the entire process. Both digital stimulation and/or pre-packaged enemas may be authorized under APC, Bowel Program.
15. If a participant needs trach care, specifically changing out the trach, can this be authorized as a task for the nurse to complete during the weekly nurse visits for med setup?
- A. Yes, this is an appropriate task for the nurse to complete. If there isn't an authorization for weekly med setup, the assessor could authorize a weekly visit for this task under "other nursing tasks". Advanced Personal Care (APC) aides are authorized to provide tracheostomy hygiene to well-healed sites only, while changing or replacing the trach remains a nursing task. Note: It is important for providers to remember that a referral shall be made to Home Health services for the participant when appropriate.
16. What is the difference between Basic Personal Care (PC) Self-administration of Medication and Advanced Personal Care (APC) Non-injectable Medication?
- A. Self-administration of medication is defined in [19 CSR 30-83.010 \(46\)](#) as the act of actually taking or applying medication to oneself. For example, time spent handing the medication container and water to the participant so that the participant can self-administer their medications would be appropriately calculated in the time for this task. This would also include guiding/steadying the hand for oral

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medications and/or inhalants. APC Non-injected medication services are defined as manual assistance with non-injectable medications as set up by a licensed nurse and may include opening a medicine lockbox, steadying the participant's hand/arm for ear and eye drops, finger sticks etc., and when prompting is required to take medication. While the two services involve the same actions by the aide, the difference lies in the participant's ability to set up/know when to take their own medications.

17. Are Advanced Personal Care (APC) aides authorized to administer vagus nerve stimulation to a participant?
 - A. This is not an allowable APC task.
18. Can a Prothrombin Time/International Normalized Ratio (PT/INR) blood test be authorized under Advanced Personal Care (APC)?
 - A. The test needs to be completed by the participant, a trained family member, or a nurse. The APC aide could steady the participant's hand and read the levels if the participant needs this assistance. This would be authorized under non-injectable medications.
19. If a participant needs prescription ointment applied to a stage II wound, can Advanced Personal Care (APC) be authorized for the application of the ointment?
 - A. No, all wound treatments beyond a Stage I are considered a nursing level task.
20. Are sit-to-stand (Hoyer) lift devices authorized under Advanced Personal Care (APC) for use? The device uses a belt that is placed around the participant's waist and lifts the participant to a standing position using hydraulics.
 - A. This type of device is considered a type of "Assistive Transfer Device" and would be authorized under APC. The provider will have to assure the APC aide is adequately trained on this device to meet the needs of the participant.
21. Is a Licensed Practical Nurse (LPN) allowed to complete both the General Health Evaluations (GHE) and the six-month Advanced Personal Care (APC) services assessment?
 - A. An LPN is allowed to complete the GHE visit under the direction of a Registered Nurse (RN) or Doctor; however, an RN must complete the six-month APC service assessments.
22. Can the application of Nystatin powder be treated the same as Nystatin Cream applications and authorized under Advanced Personal Care (APC)?
 - A. Yes, prescription Nystatin powder should be treated like Nystatin Cream application under APC.
23. If a participant requires the use of a nebulizer, but is not able to hold the aerator to participant's mouth for the entire length of time of the treatment, can the aide steady and hold the participant's hand so the participant can administer the medication on their own?

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- A. If the participant is able to administer their own medications, then it is an allowable task under Basic Personal Care self-administration of medications. For more details see number 9 in the Residential Care Facility/Assisted Living Facility section.
24. Does Missouri Medicaid Audit and Compliance (MMAC) review Advanced Personal Care (APC) tasks regarding what can be authorized?
- A. DSDS authorizes specific tasks under APC authorizations and MMAC audits to ensure the provider delivered according to the authorized care plan.
25. For participants who have difficulties swallowing, can their medications be added to their food (e.g., applesauce) by the Advanced Personal Care (APC) Aide?
- A. If the medication has been reviewed and set up for the participant by the nurse and the participant is feeding him/herself then the act of emptying the medicine out of the planner into (ensuring not to touch the medication) the participant's food can be completed by the APC Aide. The aide shall not alter (e.g., crush or mix) the medication.
26. Are physician orders required for Passive Range of Motion (PROM)?
- A. Yes, PROM is authorized based upon the participant's needs; however, the provider must obtain a copy of the physician's orders in order to deliver this task appropriately.
27. Are aides allowed to disconnect and reconnect insulin pump tubing for the purpose of bathing the participant?
- A. Yes, this would be an approved Advanced Personal Care task (APC) and the provider should ensure that the aide is properly trained to complete the task under non-injectable medications.
28. Regarding conditions for reimbursement for Advanced Personal Care (APC), the Personal Care Regulation ([13 CSR 70-91](#)) states, "The provider agency is responsible for obtaining the recipient's physician's approval for the plan." Can a nurse practitioner (NP) or physician assistant (PA) provide this approval?
- A. Yes, DHSS and Missouri Medicaid and Compliance (MMAC) will accept approval from either a physician, NP or PA as appropriate documentation for this purpose. Additionally, a NP or PA may be accepted for any orders related to HCBS services as long as they fall within the scope of the NP or PA's license.
29. Do DHSS staff need to obtain a copy of Advanced Personal Care (APC) physician orders from the provider in order to authorize services?
- A. No, this is the provider's responsibility.
30. If a participant has medication set up with hospice or home health and the provider agency is different than the In-home agency, can the personal care aide provide medication assistance to the participant?

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- A. Yes, however, the provider nurse must ensure that self-administration of meds is not already being completed by the other agency. The provider agency must also be willing to accept the liability when their employees assist the participant in self-administering medications which have been set up by another agency.

- 31. Is clean-up time associated with bowel program administration included within the bowel program time or authorized within toileting?
 - A. All steps including clean-up should be authorized under bowel program.

- 32. Can an APC aid complete any portion of the tube feeding process?
 - A. No. An aid cannot complete any part of the actual tube feeding process, they may only assist in the cleanup. Meaning they may not be authorized to mix the solution, pour the solution in the bag, or set the machine. They may wash syringes, bags, or tubing after the feeding is complete. This would be authorized as dietary under in-home and wash dishes under CDS.

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Assessment / Reassessment

1. What constitutes a physician ordered diet?
 - A. A physician ordered diet includes weighing, measuring, and/or restricting selected nutrient components. An example for diabetics would be carb counting or utilizing the glycemic index to select foods per the physicians order. A doctor simply recommending someone to “watch their sweets,” is not a physician ordered therapeutic diet. Therefore, further information would need to be gathered to see if the participant has been restricted to a certain limitation.
2. Which medications and supplements should be counted for the total number of medications to constitute a complex drug regimen for question #4 in Section M of the interRAI HC?
 - A. Any and all medications (prescription and over the counter), as well as supplements which have been prescribed by a physician to address a health condition should be counted.
3. If a participant is due for a provider reassessment and their home is in poor condition and/or there is an infestation, can the provider conduct the reassessment in the office and bill for the assessment?
 - A. It is preferred the reassessment be conducted in the participant’s home, however, this is not a requirement and there may be circumstances where a reassessment could be conducted elsewhere if the participant is agreeable. This must be documented in Case Notes. Provider staff should work with DSDS staff to ensure there is a plan to address the issues with the home. Additionally, if a participant is currently in the hospital, it is appropriate to conduct the reassessment as part of the discharge planning process at the hospital if the participant is agreeable.
4. With the recent Office of Administration (OA) changes made for HCBS Assessor requirements, what degrees would be acceptable and qualify an HCBS provider to participate in the reassessment process??
 - A. All HCBS providers must ensure assessors must have a bachelor’s degree in any field or be a Registered Nurse or License Practical Nurse licensed in the State of Missouri or four (4) years working for Division of Senior and Disability Services or four (4) years working for an Area Agency on Aging or be multi-lingual and approved through DSDS.
5. If a participant requires an Exogen machine for bone therapy as ordered by an orthopedist, would this be noted on the interRAI HC under non-preventative treatments?
 - A. Yes, although it is not a preventative treatment, it allows the bone fracture to heal and this can be considered non-routine preventative treatments under the interRAI.
6. If the participant is receiving oral chemotherapy treatment, where should it be recorded in the interRAI HC for determining Level of Care (LOC)?

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- A. Chemotherapy treatments are defined in Section N: Treatment and Procedures, but when the medication is administered orally and not intravenously, it must be recorded in Section M: Medication, as well.
7. Are providers required to keep paper copies of the forms used for a reassessment that they complete?
- A. It is not necessary to keep paper records used to conduct a reassessment, however, all documentation must be recorded in Web Tool.
8. Can you define walking versus locomotion?
- A. Locomotion is defined as: ability to move from one place to another. If in a wheelchair, self-sufficiency once in their chair.
Walking is defined as: movement at a regular and fairly slow pace by lifting and setting down each foot in turn, never having both feet off the ground at once.
9. Are assessors required to upload an Individualized Treatment Plan (ITP) into Web Tool?
- A. No, staff are only required to verify the information within the ITP. Section N6f of the interRAI should be coded based on the services being provided and the plan to obtain and/or maintain the participant's optimal highest functioning potential.
10. If assessors are looking for information regarding an Individualized Treatment Plan (ITP) and the participant does not know their case manager, how do we find this information?
- A. See [Policy 4.00 Appendix 7](#) for Department of Mental Health (DMH), Developmental Disabilities (DD) Office List.
11. What is re-motivational therapy?
- A. The National Re-motivation Therapy Organization defines it as a small group therapeutic modality, designed to help clients promote self-esteem, awareness, socialization and concentrates on the psychosocial well-being and quality of life of older adults in long-term care facilities.
12. Where do we document injections on the assessment?
- A. Injections are a means to administer medications; therefore the medication in the injection would be documented in Section M of the interRAI HC. Additionally, the assessor would document the participant's ability to administer the injections in Section G1d.
13. If we are denying Consumer Directed Services (CDS) based on inability to self-direct, does Behavioral Level of Care (LOC) need to be a 9?
- A. No, the assessor should accurately code the interRAI questions and ensure that SLUMS, Self-Direction Assessment Questions, information from a health care professional (see the Healthcare Professional

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Inquiry Form), and any other documentation (when considered in totality) support the decision regarding self-direction.

14. Does an assessor only mark yes to the Legal Guardian question if they have the supporting documents in the attachments?
 - A. No, the assessor should answer the questions accurately and make every effort to gather the documentation at a later date.
15. Should the reference date be the day you were in the home for the assessment?
 - A. Yes.
16. During the assessment, is it acceptable to ask the questions in a different order than they appear in the interRAI HC?
 - A. Yes, it may be beneficial to ask some questions out of order. For example, before answering questions in Section G regarding physical abilities, you might want to ask the participant to get their current medications. This will allow you to observe their ability to ambulate.
17. How do you document smokeless tobacco (chewing tobacco or vapor cigarettes)?
 - A. Smokeless tobacco is not included in the assessment.
18. Does the goal listed in Section A10 of the interRAI HC need to be tied to the services they receive?
 - A. No, the goal is meant to reflect anything in the participant's life.
19. Do we document in Case Notes the observations we made that are different from what the participant reports?
 - A. Yes, the assessor has the ability to gather information from observations and through collateral contacts to change the coding in the interRAI HC to accurately reflect the condition of the participant.
20. Where are assessments to be conducted? If a participant is in the hospital at the time of the assessment, do participants need to be seen in the home or can it be in the hospital?
 - A. Assessments are to be completed in the home. When there is an urgent need of services, a participant can be seen in the hospital in order to expedite the authorization of HCBS. However, a follow-up visit in the home should be made to validate the assessment and the previously completed care plan.
21. If an individual resides in a RCF, how should the assessor code meal preparation in section G1a?
 - A. Performance should be coded as a 6 – total dependence, and capacity should be coded based upon the participant's presumed ability.
22. If an individual can use a microwave or make a sandwich; how is capacity coded in section G1a?

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- A. If the individual can only do simple tasks such as microwaving or making a sandwich, code as 3 – limited assistance. However, we must look at their true ability. If a participant simply does not like to cook or feels that is the job of someone else but is capable of safely cooking, the individual should be coded as independent.
23. If an individual can bathe themselves, but must have someone present (fall risk, seizure prone), how is this coded in section G2a?
- A. Individuals only needing stand by assistance (no hands on assistance) should be coded as 2 – Supervision. If the individual requires hands on assistance, the assistance should be scored based on the amount of weight bearing assistance needed.
24. If an individual only needs help getting in and out of the tub, how is this coded in section G2a?
- A. This answer depends on the level of weight-bearing support that is required. The assessor may need to gather information from the caregiver(s) to determine this information.
25. Should stress incontinence be considered in Section H?
- A. Yes
26. If an individual with a developmental disability becomes preoccupied in certain situations and is incontinent as a result, how is this scored in section H?
- A. Section H should be coded based on the frequency of the incontinence regardless of the circumstances.
27. If an individual is a quadriplegic or paraplegic, how is this coded J3 – Balance?
- A. J3A – Difficult or unable to move self to standing position unassisted would be scored as 4 – Exhibited Daily
J3B – Difficult or unable to turn self around and face the opposite direction when standing would be scored as 4 – Exhibited Daily.
J3D – Unsteady Gait would be scored as 0 – not present as this individual is not able to display a gait.
28. How do we count the meds that are “taken as needed”?
- A. Per regulation, medications taken as needed (PRN) are counted if they have been taken in the last thirty days.
29. If a treatment involves the use of a medication (e.g. nebulizers, chemotherapy) should the medication be counted in Section M in addition to be being scored in Section N?
- A. Yes, if the medication has been taken in the last 3 days or on a regular maintenance schedule.

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30. Are herbal supplements counted?
- A. Prescribed herbal supplements are to be counted in M1. Non-prescribed herbal supplements are to be counted in M2.
31. If the participant refuses to show the assessor their medications should they be counted in section M.
- A. Medications should only be counted if they can be verified. If the assessor is unable to do this in the home, other means can be utilized such as information in Cyber Access or contact with the pharmacy or physician.
32. If chemotherapy treatments are done every couple weeks or at a more spaced out schedule, how is this coded in Section N2?
- A. This would be coded as a 1 – ordered, not yet implemented, unless their treatment occurred within the last three days, in which case it would be coded a 2 – 1-2 of last 3 days. Ordered chemotherapy will produce the same LOC score regardless of how often it is received. Case Note clarification should be provided to further explain the situation.
33. How is tele-monitoring scored?
- A. Telemonitoring is to be coded in N7 based upon the stability of the participant and the frequency of the monitoring. The LOC score would vary depending on stability and frequency coded.
34. Are chiropractic services considered a treatment?
- A. No
35. How would an assessor code if physical therapy is ordered, but the participant refuses to attend the sessions?
- A. The interRAI HC states the ‘extent of care/treatment in the last 7 days. If the participant is not receiving therapy then ‘0’ should be entered in the related therapy category.
36. What constitutes as an acceptable Individualized Treatment Plan (ITP) in section N6?
- A. ITPs must contain written goals that are tracked and updated according to progress.
37. Do we document in case notes the observations we made that are different from what the participant reports?
- A. Yes, the assessor has the ability to gather information from observations and through collateral contacts to change the coding in the InterRAI HC to accurately reflect the condition of the participant.

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38. If someone is being monitored by a health professional for a mental health condition, what credentials does the health professional need to have in order for that person to receive points in section N7 monitoring?
- A. The health professional must be a licensed mental health professional, or be a physician.
39. If an individual resides in a RCF and the facility dispenses all medications to the residents, how should this be scored under performance on question G1d – Managing Medications?
- A. If the individual remembers when to take their medications and goes to the medication dispersion area without being prompted, then score as a 5 – Maximal Assistance. If the individual does not remember when to take their medications and relies completely on the facility for medication management, score as a 6 – Total Dependence.
40. In Section I – Disease Diagnoses, when is it appropriate to code a diagnosis as 1 vs 2?
- A. 1 – Primary diagnosis/diagnoses for current stay should be used for the primary reason the individual is in need of services. The term “current stay” is often confused as hospital or facility stay but should instead be seen as the reason for services. 2 – Diagnosis present, receiving active treatment should be used for other diagnoses that the individual is receiving treatment for but that are not the primary reason services are needed.
- Ex: An individual just had a stroke and now has paralysis on the right side of their body. They also have diabetes and depression. The individual receives treatment or takes medications for all diagnoses but up until the stroke the individual was able to perform all activities on their own with the diabetes and depression. In this scenario “stroke” would be coded as 1 as this is the primary reason the individual is now requesting services. Diabetes and depression would be coded as a 2 as they are receiving active treatment but they are not what led to the need of services.
41. How does an assessor code the following treatments? Are they scored under treatments (N2), medications (M1) or both?
- A. **Pain Pump:** Both. The medication for the pain pump would be coded under M1 if used in the last 3 days or on a regular maintenance schedule. The pump would be coded under N2 as an IV medication.
- Insulin Pump:** Medications. The medication for the pump would be coded under M1 if used in the last 3 days or on a regular maintenance schedule. By only coding under medications, this allows insulin regimens (shots, pump, oral) to be scored the same way.
- Pain Implant:** Treatments. This would be coded under N2p – other non-routine preventative treatments.
- Life Vest:** Treatments. This would be coded under N2p – other non-routine preventative treatments.
42. How is section N7 – monitoring coded for the following?

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- A. **Home Health:** Monitoring must be completed by a physician or licensed mental health professional. Monitoring by a nurse does not count toward this question. The assessor must determine how often the physician is monitoring the nurse's notes, etc.
Heart Monitors: Similar to home health, the assessor must determine how often a physician is reading the results from the heart monitor.
43. If an individual with balance and/or gait issues reports a near fall in the last 30 days but states they luckily caught themselves on a wall or furniture, is this coded in question J1 - falls?
A. Yes, this is still considered a fall.
44. If an individual must brace/push themselves out of seated position using the chair arms or requires assistance of a cane/walker, is this coded as difficult to stand in section J3a even though they are able to complete the task without assistance of another individual.
A. Yes, if the individual is unable to rise without the weight bearing assistance of the device or chair.
45. What constitutes wound care in question N2k?
A. The skin must be broken in order for the assessor to code wound care. Application of ointments/creams to unbroken skin or rashes does not count. Prescription ointment/creams for this reason may however be coded in section M1 if used in the last 3 days or on a regular maintenance schedule.
46. If an individual requires the support of a handrail and a break when climbing a flight of stairs, how should this be coded in section G1f-stairs?
A. If the individual is able to safely complete the task without assistance, this should be coded as independent. If there is concern for safety, the individual should be scored at the amount of assistance needed to eliminate the concern for safety.
47. If an individual does not have a car or license (but is physically/mentally capable of having one), how does this information impact coding in section G1h?
A. Section G looks at the individual's ability. The lack of a car or license is a resource issue and should not be considered in the coding of this question.
48. If an individual needs assistance with nail care, can this be coded in section G2b-personal hygiene?
A. No. Section G2 only captures activities of daily living (ADL). Because nail care is usually only completed once a month, it would not be captured as an ADL.
49. If a participant only needs help with buttons, snaps, bra clasp, etc. due to dexterity difficulty, how should this be coded in section G2c-dressing upper body?
A. If there is no need for weight bearing support, this should be coded as 3-limited assistance.

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50. If a participant only needs help with shoes and socks, how should this be coded in section G2d-dressing lower body?
- A. If there is no need for weight bearing support this should be coded as 3-limited assistance.
51. If an individual lives in a Residential Care Facility (RCF) or Assisted Living Facility (ALF), how should this be coded for questions A12 and B4?
- A. If the individual lives in a RCF, A12 – Residential/Living Status should be scored as 2 – Board and Care. If the individual lives in an ALF, this should be scored as 3 – ALF. “Other” should not be selected for either of these facility types.
- B4b – Residential History of board and care home, assisted living should be coded as 1-yes. These two questions should align if the individual is currently residing in a facility.
52. If an individual utilizes a prepackaged medication set up from the pharmacy, how should this be coded in G1d-Managing Medications?
- A. If an individual does this simply for convenience but is able to manage them on their own, code as 0-Independent. If the individual is in need of the medication set up and could not manage on their own this should be coded as 4-extensive assistance only help only if they are able to do the rest of the medication administration process after the pharmacy set up. If additional help is needed with medications the individual should be coded at the appropriate level.
53. Should fluid restrictions be counted under K2e – physician ordered diet?
- A. Yes, if the fluid restriction is physician ordered outlining a specific amount of fluid that may be taken in each day. Fluid restrictions are most commonly prescribed to individuals diagnosed with congestive heart failure and end stage renal disease.
54. Can a brace be coded as a non-routine preventive treatment – N2p?
- A. No, this is not considered a non-routine preventative treatment however, assistance needed to apply the brace may be considered in dressing – G2c & G2d.

HCBS Policy Clarification Questions

Authorized Nurse Visits

1. Do Authorized Nurse Visits need to remain strict with a certain day allotted each week for the visit?
 - A. There is no requirement that the Authorized Nurse Visit be no sooner than every seven days. The Authorized Nurse Visits should be completed based upon the needs of the participant.

2. If participants request to have the current week and back-up medicine planner filled in the event there is inclement weather or physician appointments, is this allowed under the Authorized Nurse Visits program?
 - A. There are no restrictions against filling a backup medicine planner.

3. If a participant does not have Home Health and is requesting Authorized Nurse Visits for assistance flushing out a port, is this a task that can be authorized under Other Nursing Services?
 - A. This would be an allowable task under “Other nursing services.” Please remember when authorizing this service, only 26 units in a 6 month time period is allotted for Authorized Nurse Visits. If the port must be flushed more than once a week over a 6 month period, there would not be enough Authorized Nurse Visits to cover the task. Home Health would then be more appropriate for this task.

4. Can Nurse Visits be authorized for oversight of an Advanced Respite Aide for a participant who has Aged and Disabled Waiver (ADW) services, Advanced Respite and Basic Personal Care (PC) for medication assistance and nail care, but not an Advanced Personal Care (APC) authorization?
 - A. No. Nurse visits should only be authorized when there is an identified nursing need or if there is an APC authorization. Nurse visits should not be authorized just for the oversight of an Advanced Respite Care aide or to assure the Advanced Respite Care aide is adequately trained. This does not negate the provider’s responsibility for oversight and training for aides delivering Advanced Respite.

5. If a participant is receiving Home Health and all weekly/monthly tasks authorized by DSDS are being performed by the home health nurse, should the provider complete a General Health Evaluation (GHE) during the month?
 - A. The Nurse Visit authorized for the GHE should be completed as normal. Regarding delivery of other services during this type of situation, HCBS authorized by DSDS staff are not to be duplicative of informal and formal supports such as Home Health. While Home Health services are being delivered to a DSDS participant, duplicative Advanced Personal Care (APC) and/or Personal Care (PC) (and possibly other services) are put ‘on hold’ until the home health services have discontinued.
If it is determined that the APC service is necessary as it is not duplicated by the Home Health, then the provider nurse continues to be required to complete the monthly nursing oversight responsibility for the APC aide and APC service.

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6. If a participant has two different providers in the home, one delivering services in the morning and the other in the afternoons and on weekends, and both are providing Advanced Personal Care (APC), is it permissible to authorize nurse visits for the purpose of APC oversight to each of the providers?
 - A. Yes, however, the authorization may not exceed the limit of 26 units within a 6 month timeframe.
7. Can Nurse Visits be authorized more frequently than once per week?
 - A. Yes, Nurse Visits may be authorized as often as needed but the provider may not exceed 26 visits in a 6 month time period. Other nurse sources such as Home Health should be explored as they may be a better fit, however if that is not an option, short term frequent visits may be authorized. This would not be an ideal option for a participant that needs other weekly visits throughout the year such as medication set up as this will leave them with weeks without any leftover visits available to complete the task. Case note clarification is needed to explain the situation and insure over authorizations do not occur. The provider should be reminded to not exceed the 26 visit limit. Participants only accessing the nurse visits for a short term need such as dressing changes should only be authorized for the number of weeks they are needing the services. For example: If someone needs dressing changes 4 times per week, they should only be authorized for 6 weeks as after that 6th week they exceed the visit limit.
8. If an individual is on an aspirin regimen, does this constitute a medical need for authorized nurse visits for nail care?
 - A. No. Nail care in this instance should be authorized under dressing and grooming unless there is a doctors order or another medical condition that constitutes the need for a nurse to provide nail care. Advanced anticoagulant therapies such as Coumadin do however indicate a need for nurse authorization.
9. Do tremors constitute a medical need for authorized nurse visits for nail care?
 - A. Not necessarily. A doctor must indicate a need through an order for a nurse to complete the task.
10. When can authorized nurse visits be used for an acute situation such as wound care?
 - A. Participants may be authorized for RN visits for specific tasks when the needs of the participant cannot be met and are not reimbursable through the home health program. Meaning the participant must be denied or unable to receive home health. The assessor should ensure this is accurate information by checking with the physician before authorizing. This will only occur in rare instances. Thorough documentation should be provided in the case notes.
11. Can vaccines be provided during Authorized Nurse Visits? If so, does a onetime authorization need to be added to the care plan for that the task to be completed?
 - A. Yes, vaccines may be completed during authorized nurse visits if there is a physician order. If a participant already has regularly scheduled nurse visits (ex: med setup), the vaccine should occur at the regularly scheduled visit and a one-time authorization to the care plan shall not be added. If a

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participant does not have regular nurse visits, a one-time authorization will need to be added in order to allow the provider to bill for the nurse visit. Providers do not need to contact the PCCP team to notify them of vaccine administration unless a one-time visit authorization is needed.

12. How are the 26 visits per six months counted? Is this based on a calendar or assessment year?
 - A. Assessment year. The first 6 months following the authorization period, and then the second 6 months of the authorization period.

HCBS Policy Clarification Questions

Consumer Directed Services

1. If a potential participant has a Power of Attorney (POA) does this make him or her ineligible for Consumer Directed Services (CDS)?
 - A. The fact that the potential participant has a Power of Attorney does not make the participant ineligible for CDS. The potential participant must have the ability to self-direct their own care in order to qualify for CDS.

2. Once authorized in Web Tool, when must services start for Consumer Directed Services (CDS)?
 - A. There is no timeframe established in Statute or Regulation for the CDS model, however, it is the responsibility of the vendor to maintain a list of eligible attendants in cases of participants needing immediate care, etc.

3. If an applicant was placed on the Employee Disqualification List (EDL) due to committing fraud as a Consumer Directed Services (CDS) attendant, does this disqualify them from receiving CDS themselves if they meet the qualifications and have applied?
 - A. In reviewing our policy, the Code of State Regulation, and statute, there is nothing which indicates this history would prevent the individual from potentially becoming a CDS participant. As long as the participant meets level of care and all other CDS program requirements, there are no restrictions from receiving CDS despite the fraudulent activity from when he/she was an attendant.

4. Is an aide allowed to provide Consumer Directed Services (CDS) to a participant while out of state?
 - A. Currently, there is nothing in regulation which says an attendant cannot be paid or is not allowed to provide services to the consumer out of state. It's reasonable to assume that a CDS participant who needs assistance with Personal Care at home would also need care when he/she travels to another location. The vendor must still be able to ensure appropriate delivery of services, and the travel out of state must be temporary.

5. If a participant is in a same-sex marriage and participant qualifies for Consumer Directed Services (CDS) and is in need of services, can the spouse work as the aide for the consumer?
 - A. With the new ruling now that Missouri recognizes same sex marriages, the spouse can no longer be the paid CDS attendant. Please refer to [PM/VM-16-09 Same-Sex Spouse as a Paid Aide or Attendant](#).

6. Is it possible to have two Consumer Directed Services (CDS) attendants in the home of a participant who is receiving chemo and sleeps most of the day, to perform Personal Care tasks at a quicker pace, so not to disrupt the participant while they are sleeping?
 - A. It is not a possibility due to the one service code per participant at one time requirement for Medicaid billing. Even though the aides would perform different tasks, it would fall under the CDS billing code.

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However, it is possible to have two attendants in the home at one time as long as they are performing different “service types”. For example, CDS cleaning tasks and Nurse Visits.

7. Does the 21 day rule regarding advance notice to the participant prior to discontinuing services pertain to Consumer Directed Services (CDS)?
 - A. No, it does not. Below is the applicable regulation regarding discontinuation of services in the CDS program.
 - (A) Vendors after notice to the Department of Health and Senior Services (DHSS) may suspend services to consumers in the following circumstances:
 1. The inability of the consumer to self-direct
 2. Falsification of records or fraud
 3. Persistent actions by the consumer of noncompliance with the plan of care
 4. The consumer or a member of the consumers household threatens or abuses the attendant and/or vendor
 5. The attendant is not providing services as set forth in the plan of care and attempts to remedy the situation have been unsuccessful
 - (B) Shall provide written notice to DHSS and the consumer listing specific reasons for requesting closures or termination. All supporting documentation shall be maintained in the consumer’s case file. DHSS shall investigate the circumstances reported by the vendor and assist the consumer in accessing appropriate care. Upon a finding that such circumstances exist, DHSS may close or terminate services.
8. Are physician orders required for Consumer Directed Services (CDS) participants with Advanced Personal Care (APC) type tasks (e.g., Passive Range of Motion)?
 - A. This is not a requirement of the regulation under CDS.
9. Is it acceptable for a Consumer Directed Services (CDS) attendant to be listed as a consumer’s payee?
 - A. Only legally responsible individuals (court appointed guardian or conservator) and spouses are prohibited from being an attendant in the CDS program. There is nothing that prohibits a payee from being an attendant, however, the vendor may want to include more oversight in this type of case and the vendor always has the right to create more restrictions than required by statute and regulation.
10. Are Consumer Directed Services (CDS) consumers allowed to use all their “daily” units each month regardless of whether it is a “short” month?
 - A. Missouri Medicaid Audit and Compliance’s (MMAC) expectation is that anything billed needs to be authorized, delivered, and adequately documented. In certain circumstances, the participant may need to use more services in a certain day, thus utilizing all of their monthly units in a short month. The provider shall document and bill as delivered (for example, the participant has the stomach flu and needs extra bathing time and toileting time).

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11. What is the difference between Case Management in the Independent Living Waiver (ILW) and Case Management required by Consumer Directed Services (CDS) providers for all CDS consumers?

A. Regulations state that CDS vendors must perform “case management activities with the consumer at least monthly to provide ongoing monitoring of the provision of services in the plan of care and other services as needed to live independently”. Please refer to [VM-07-18 Vendor Oversight](#) for detailed information regarding this requirement. There is also a service in ILW entitled Case Management. This service is defined as “service that assists participants in gaining access to needed Waiver and other State Plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.”

Case Management through the ILW includes:

- Identification of abuse, neglect, and/or exploitation;
- Monitoring of the provision of services in the participant’s care plan;
- Review of the care plan and the participant’s status, which shall include monthly contacts, and face-to-face visits with the participant as deemed necessary; and
- Assist the participant with full access to a variety of services and service providers to meet their specific needs, regardless of funding source.

12. Can a minor be hired to work for a consumer if the individual has previous experience in the caregiver role and a “Certificate to Employ a Child 14 to 15 Years of Age during Non-School Terms?”

A. No. The regulatory requirements governing the Consumer Directed Services (CDS) program ([19 CSR 15-8](#)) does not give exception to the criteria to be employed as a personal care attendant.

13. Should participants who are authorized for Consumer Directed Services (CDS) receive a General Health Evaluation (GHE) when they are authorized for Nurse Visits for other purposes?

A. No. Participants who are authorized for CDS are not to receive a GHE, even when the participant is authorized for Nurse Visits for other purposes.

14. Is an attendant allowed to assist in operating (turning the machine on/off) an in-home dialysis machine, hang the bag, place the bag in the machine or connect the tubing to the participants dialysis catheter, under Consumer Directed Services?

A. No. Dialysis tasks are beyond the scope of the personal care program and cannot be authorized. Cleaning with soap and water around any well-healed site, including peritoneal port sites would be allowed under catheter hygiene.

15. If an individual needs technical assistance with telehealth calls, can time be authorized under essential correspondence?

A. Time may be authorized for the set up portion of the call.

HCBS Policy Clarification Questions

Consumer Directed Services/Transportation (Essential Transportation)

1. Is transporting to reading classes for reading comprehension allowable?
 - A. Yes, this is considered “continuing education” and is allowable under Essential Transportation.

2. Is transporting for events such as: visiting another individual’s home for social visits, or visiting someone in the hospital or a church/church function allowable?
 - A. Social activities are not appropriate as they do not meet the definition of essential transportation. This does not mean that the attendant cannot take them to the destination and deliver appropriate and authorized personal care tasks while the participant is in that location. The transportation may not be reimbursable, but the personal care is.

3. Is transporting to a funeral home to make funeral arrangements for someone else allowable?
 - A. If it is necessary to go to the funeral home to make arrangements for a relative whom the participant is responsible for and no other transportation options are available, then this would be an essential transportation need and thus allowable.

4. Is transporting to an appointment to have blood drawn for lab work (when Medicaid does not pay for the service and it is performed separately from a doctor visit) allowable?
 - A. Trips for medical appointments or health oriented appointments (lab draws, chiropractor, etc.) are always considered to be appropriate tasks for Essential Transportation as long as it is not a Non-Emergency Medical Transportation (NEMT) covered trip.

5. If a participant is wheelchair bound and unable to transfer to and from or assist in placing their wheelchair in the vehicle without assistance, and Non-Emergency Medical Transportation (NEMT) is not assisting, can Essential Transportation be authorized?
 - A. No, the participant should submit a complaint through MO HealthNet regarding this issue. Problems with an NEMT provided service is not justification to authorize the service through Consumer Directed Services (CDS).

6. Is transporting to a storage unit or facility for the purpose of relocating possessions from a home as ordered by the participant’s landlord or owner of property or face eviction allowable?
 - A. Yes, this would be considered ‘essential’ since removing the items is necessary so the participant can remain in the home.

7. Can a participant have a family member or friend ride along?
 - A. This is a decision between the vendor, attendant, and consumer. DHSS does not have a regulation prohibiting this practice.

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8. If two participants live in same household and both are authorized for transportation and prefer to conduct joint shopping for groceries, can the aide document the first 30 minutes for one participant and second half hour for the second participant, in order to save the aide from having to make two trips to the store?
- A. Yes, it is appropriate to document this way as long as the times do not overlap one another and the participant's needs are being met.
9. Is transporting to physical therapy sessions (including aquatic) allowable?
- A. Non-Emergency Medical Transportation (NEMT) must be utilized prior to Consumer Directed Services (CDS) transportation. If the participant discovers the physical therapy does not qualify for NEMT, the attendant can transport the participant to and from the physical therapy appointment. However, while the participant is with the physical therapist, any time the attendant spends waiting for the participant to complete the therapy session cannot be reimbursed.
10. Can Non-Emergency Medical Transportation (NEMT) providers transport the participant and the participants Consumer Directed Services (CDS) attendant as a "rider" for attendance and assistance needed during medical appointments (mobility concerns of participant)? Will the attendant need to pay for their transport spot? If not, who is responsible for the cost?
- A. The NEMT broker would be able to take the participant and an additional rider. It would need to be conveyed that the participant would need the additional rider at the time the reservation is made. The participant would be the only one that would be asked to pay copay for the transportation and not the additional rider.
11. If the participant has a physician order for water aerobics/swimming with Passive Range of Motion (PROM) each week and needs a ride to and from the swimming classes, can it be authorized under essential transportation?
- A. Passive Range of Motion is an allowable task under Consumer Directed Services (CDS) and if the water aerobics/swimming course is taught by a trained therapist, then it is allowable. However, if they are not trained in that type of therapy then the participant would need to find other means of transportation to and from the class. Also, the vendor would need to verify this would not be covered under Non-Emergency Medical Transportation (NEMT). Reimbursement for waiting on the participant is not allowed.
12. Are attendants allowed to run errands (grocery shopping, pharmacy, etc.) on behalf of the participant by means of public bus transportation?
- A. There is nothing in statute or regulation which prohibits this or requires the use of the attendant's personal vehicle. In some instances, a taxi has been used.

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13. Can a Consumer Directed Services (CDS) attendant complete all necessary shopping/errands for the participant without the participant accompanying them?
 - A. Yes, [Policy 3.25 Personal Care Assistance – State Plan \(Consumer Directed Services Model\)](#), states that all essential shopping/errands (whether or not the participant is with the CDS attendant) are covered services.

14. Can time spent driving the participant to and from their place of employment be authorized for transportation?
 - A. Yes, [Policy 3.25 Personal Care Assistance – State Plan \(Consumer Directed Services Model\)](#), defines Essential Transportation as all essential shopping/errands (whether or not the participant is with the CDS attendant), medical appointments not covered under the Non-Emergency Medical Transportation (NEMT) program, school, or employment, etc.

15. Do either appointments for PT/OT or appointments across state lines indicate an automatic denial for NEMT and verify a need for essential transportation?
 - A. Neither of these scenarios are listed on NEMT’s site as trips that would automatically be denied. The assessor/participant should confirm with NEMT before authorizing essential transportation in these 2 scenarios.

16. If a participant’s groceries are bought at the same time as the household’s, can this time be authorized under essential transportation?
 - A. If the purchased items are a benefit to others in the household, time cannot be authorized for the shopping of these items.

HCBS Policy Clarification Questions

CyberAccess / WebTool

1. Is it appropriate to place the diagnosis of the participant into the Case Notes within WebTool?
 - A. It is appropriate to document in Case Notes the specific diagnosis of a participant, although not required, as it should already be documented within the interRAI HC. When a provider, worker, or medical professional logs into Cyber Access, they are agreeing to the HIPAA confidentiality rules. They also have access to the diagnosis in Cyber on other screens as well.

2. Is it appropriate to place a safety concern into case notes within WebTool? Example: A 21 day notice was received regarding a provider who was not feeling safe sending an aide to a home due to an altercation in the home and being informed that the participant allegedly stabbed someone within the home.
 - A. It is appropriate to document safety concerns within Cyber. Please refer to [PM/VM-16-03](#). Confidential information regarding a hotline should not be entered into Case Notes.

HCBS Policy Clarification Questions

Documentation

1. If a participant is utilizing paper timesheets in lieu of Electronic Visit Verification (EVV), is it necessary for an aide/attendant to submit a hard copy of the original signed timesheet to the provider/vendor, or are electronic copies of the timesheet acceptable?
 - A. Paper timesheets are no longer appropriate. Providers and participants must utilize EVV for personal care services.

HCBS Policy Clarification Questions

General

1. Is assisting with homework an authorized task under essential correspondence?
 - A. If this task is covered through Department of Education and Secondary Education (DESE) Vocational Rehabilitation, it is not appropriate for Essential Correspondence. However, if it is not a task covered by DESE, time spent directly assisting the participant (i.e. opening books, turning page, reading, etc.) are covered. If the participant is unable to type or write the provider should contact DSDS to assist with locating resources for adaptive equipment.

2. If a participant has a service dog, is it allowable for the aide to take the dog for walks/to potty?
 - A. These are not allowable tasks and cannot be authorized and added to the participant's care plan.

3. If a provider requests the name and DCN of a potential participant in order to review the participant's case history and determine if provider is willing to accept the participant, is it acceptable for state staff to provide the DCN?
 - A. Yes, this gives them a chance to review the care needs, history and potential safety concerns and make an informed decision as to whether or not to serve the individual. Please verify with the participant that they are interested in this potential provider before releasing the information.

4. Are DSDS staff allowed to tell providers that the participant they are assisting is on the sex offender registry?
 - A. If DSDS staff has knowledge they may share this with the provider. Additionally, information regarding sex offender status is considered a safety issue and can be documented in case notes.

5. If a participant does not utilize all authorized weekly units, can the provider and vendor schedule the time missed in that week or any time prior to the months end?
 - A. If authorized units are missed in a week, providers should document appropriately (e.g., the aide did not have time, participant refused, participant was ill, etc.). It is not appropriate to schedule these units for the purpose of being able to bill for the entire monthly authorization. However, if the participant needs additional services throughout the remainder of the month, the provider can document and serve accordingly with any units not previously used. If the provider determines the additional service is a long-term need, this information should be communicated to the [Person Centered Care Planning \(PCCP\) Team](#) for a care plan change.

6. Can 5th week hours be scheduled in shorter months?
 - A. 5th week hours should not be scheduled in months with four weeks, but can be utilized if necessary and documented appropriately.

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7. When the actual delivery of services does not match the amount of time authorized for that specific task, how should units be billed?
 - A. Authorized units are developed through a person centered care planning process with the participant in order to reflect the time necessary to complete the tasks. The suggested times and frequencies of tasks are suggestions which provide a guide for the assessor to develop an appropriate care plan to address unmet needs of the participant. Because the minutes to complete the task do not always equal exact unit increments, Web Tool automatically calculates to a full unit and allows providers to have enough time to complete all task times and frequencies in the care plan. Providers should document the time actually spent delivering the services and bill accordingly.
8. If a participant needs help packing their belongings due to an eviction notice, can additional time be authorized to assist?
 - A. To help the participant pack due to an eviction notice can only be authorized as a Chore task; and authorization for Chore tasks are funded through the Aged and Disabled Waiver (ADW) only. If the participant is not eligible for ADW services, a hotline should be made to address the situation.
9. Are providers required to conduct tuberculosis (TB) testing on their aides providing HCBS?
 - A. There is nothing in regulation that requires In-Home or CDS providers to complete TB testing on their staff. However, providers must report any communicable disease, which includes TB, in accordance with [19 CSR 20.20.020](#).
10. Can a participant be in multiple HCBS Waiver programs?
 - A. No. Participants cannot be authorized for multiple HCBS Waivers, regardless of which state agency administers the other waiver.
11. Can the required on the job training be in a classroom style setting instead of in the participant's home?
 - A. The Personal Care (PC) manual explains the designated trainer(s) may perform training during an on-site visit to a participant or in a classroom demonstration as long as it is performed within 30 days of the first date of employment.
12. Can the required New Employee Orientation Training for provider agencies be held via Skype or other live online video training platforms?
 - A. For the required eight hours of classroom training and Advanced Personal Care (APC) oversight, as noted in [13 CSR 70-91](#), the use of a video platform, such as Skype, for this portion of the training would be allowed.
13. If a Family Care Safety Registry (FCSR) finding is no longer a disqualifier, will it still show up on the background screening?

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- A. Yes. The FSCR is required by statute to report all findings that show up on the background screening, not just those that may disqualify the registrant. It will be the responsibility of the employer/provider to compare the screening results to the list of disqualifiers outlined in Section 192.2495, RSMo, to determine whether or not the employee is eligible. If a provider/employer has questions about eligibility, they will need to check with their respective regulatory or contracting unit(s). FSCR is not authorized to make eligibility determinations or to advise providers regarding statutory, regulatory or contractual requirements. Providers who contact the FSCR with these types of questions will be redirected to their respective regulatory or contracting units, as they are currently.
14. If a person has a background finding that is not a disqualifier, but the employer is uncomfortable based on the finding, will the Good Cause Waiver panel make a decision on behalf of the employer?
- A. No. The hiring decision is the responsibility of the employer. The DHSS panel is authorized to make Good Cause Waiver decisions only regarding applicants who are disqualified based on the background screening findings listed in statute. If a Good Cause Waiver application is received for an individual who is not disqualified based on what is listed in statute, the application will be rejected (i.e., will not be considered) and the applicant and/or employer will be notified. The hiring decision always remains with the employer/provider, even if a finding is not a disqualifier, there are no findings, or the applicant has a Good Cause Waiver. For example, an applicant may not have a felony theft on his or her record, but has a string of misdemeanor and/or local ordinance thefts. Even though the applicant would not be disqualified per statute, the provider might still make the decision not to hire due to the pattern of “lesser” thefts.
15. Is an employer/provider required to request the status of a Good Cause Waiver prior to hiring an employee who currently has a waiver on file, but does NOT have a disqualifying finding?
- A. No. It is recommended the employer/provider request a current background screening from the Family Care Safety Registry and compare the screening results to the list of disqualifiers outlined in Section 192.2495, RSMo, to confirm if the employee is eligible for hire. Questions regarding eligibility should be directed to the employer/provider’s regulatory or contracting unit(s). The hiring decision always remains with the employer/provider.
16. If an HCBS provider employee tests positive for THC and presents a medical marijuana certificate from a physician is the employee allowed to perform their work?
- A. It is ultimately the provider agency’s responsibility to decide their own employment policies and practices in relation to this subject matter. The provider’s policies and practices should be guided by their interpretation of Missouri’s constitution, patient rights, and may be subject to continued case law interpretation. If it is not in the best interest due to the nature of the work”, an employer may chose not to employ people who have tested positive for THC, regardless if they have a prescription or not.

HCBS Policy Clarification Questions

17. Does HCBS allow the authorization of any type of assistance with Medical Marijuana?
 - A. No. Medical marijuana is not legal under federal law and cannot be authorized under any service type.

HCBS Policy Clarification Questions

Agency Model Personal Care (In-Home Services)

1. Once authorized in Web Tool, when must services start for In-Home Services?
 - A. Regulation requires the provider shall begin providing services within 7 days of receipt of the care plan and acceptance of the participant.

2. If a participant requires tube feeding, is the aide allowed to physically hang the bag for the participant if they are not able to do so themselves?
 - A. No, any assistance with tube feeding requires the assistance of a nurse or trained family member.

3. Can a family member become the in-home aide for a participant?
 - A. As outlined in [13 CSR 70-91](#) Personal Care (PC) Program, an in-home personal care worker may not be an immediate family member of the recipient for whom personal care is to be provided. An immediate family member is defined as a parent; sibling; child by blood, adoption or marriage; spouse; grandparent or grandchild.

4. How are the areas within a participants home that need to be cleaned and picked up determined and what specifically is the aide responsible for cleaning?
 - A. Per [19 CSR 15-7](#), “The range of homemaker, chore, and respite activities the in-home worker provides is mutually determined by the provider agency and the client.” HCBS is person-centered and therefore, each participant’s specific circumstances, living arrangements, home conditions, abilities, and unmet needs should be assessed when making this determination.

5. Can a great grandchild become the in-home aide for a participant?
 - A. There is no regulation stating great grandchildren are prohibited from becoming the aide and it is allowed so long as the provider agency approves.

6. Is the use of a signature stamp allowed for a participant who is unable to physically sign their name?
 - A. Yes, the use of a signature stamp is allowed in the event the participant is not able to sign their own name. Pursuant to [13 CSR 70-91](#), for each date of service the signature or mark of the recipient must be recorded.

7. Is a General Health Evaluation (GHE) required if the participant has only Personal Care, Medically Related Household tasks authorized?
 - A. Yes, the GHE shall be authorized for all state plan agency model participants. [Policy 3.15 Authorized Nurse Visits- State Plan-Agency Model](#) states General Health Evaluation (for purposes of the semi-annual nurse visits) shall be selected as a task for participants when no other nursing need is identified.

HCBS Policy Clarification Questions

8. What is the standard time allowed per meal without any additional accommodations needed?
- A. The suggested times and frequency for Dietary noted is 10-60 minutes, 1-7x/week. [See Policy 3.05 Basic Personal Care](#) for all suggested times and frequencies. The suggested times and frequencies are provided for these tasks as a tool to help facilitate a conversation between the participant and assessor. The time required to complete a task is mutually identified and agreed upon. If the time to complete a task varies greatly from the suggested time and frequency in a particular care plan, the reasons for the deviation shall be documented in case notes. [See Policy 4.20 Person Centered Care Planning and Maintenance](#) for additional guidance.
9. If the participant is in need of a haircut, is it allowable under Personal Care (PC)?
- A. No. This would not be considered an allowable PC task.
10. Is the aide allowed to reside within the same household as the participant?
- A. Yes. In reviewing the Code of State Regulation there is nothing which prohibits the aide from residing in the same household as the participant.
11. Is the act of transferring a participant included within other tasks or should all transfer time be authorized under mobility/transfers.
- A. If a task such as bathing or toileting includes the need for a transfer, the transfer time should stay with that task. If transfer is done outside of another task such as moving from a bed to wheelchair, that time should be authorized under mobility/transfers.
12. If a participant is a safety concern (e.g. fall risk, developmental disability and at risk for burning self, etc) and needs stand by assistance during a bath to ensure safety, can time be authorized under bathing even if hands-on assistance is only available in case of safety issue arising?
- A. Time may be given for individuals that are at risk for safety concern while bathing. When possible, such the assessor should help the participant obtain resources such as a grab bar or shower chair to help decrease/eliminate the need for this time. If a participant can safely do the task with adaptations (grab bar, shower chair) the time should not be given or should be removed from the care plan once the adaptations are put into place.
13. Incontinence can lead to a need of variety of tasks such as laundry, bed linen changes, dressing, toileting, and bathing. How should the assessor decide which tasks to authorize in these instances?
- A. This type of scenario can vary greatly. The assessor should choose a person centered approach and provide case note documentation for the increased need for incontinence assistance within all associated tasks.

HCBS Policy Clarification Questions

Respite Care

1. What is the difference between Basic Respite Care and Advanced Respite Care and when is each type appropriate?

A. Respite care services are maintenance and supervisory services provided to a participant in the individual's residence to provide relief to the caregiver(s) that normally provides the care. Respite Care can be authorized in two categories: basic or advanced. Basic Respite provides services to participants with non-skilled needs who are unable to perform activities of daily living (ADLs). Basic Respite authorizations are not appropriate for participants who will have an Advanced Personal Care (APC) need during the respite period.

Advanced Respite services are authorized to help participants with special care needs, and those who require a higher level of personal oversight. (e.g. an individual with dementia who cannot be left home alone safely, or is violent or wanders).

2. Are in-laws of the participant allowed to become paid caregivers for Respite services?

A. Yes, [19 CSR 15-7.021 \(18\)\(H\)](#) does not prohibit an in-law from being a paid caregiver.

3. Can a respite attendant live with the participant?

A. Respite Care services provide relief or substitution of care for the caregiver(s) that normally provide the care. As long as the respite attendant is not the primary caregiver(s), there is nothing in regulation or policy that prohibits the attendant from living with the participant. However, the attendant must meet the requirements of an in-home personal care worker. Per 13 CSR 70-91.010 an in-home personal care worker "may not be a family member of the recipient for whom personal care is to be provided. A family member is defined as a parent; sibling; child by blood, adoption or marriage; spouse; grandparent or grandchild."

4. What is the definition of a primary (unpaid) caregiver?

B. Someone who provides or arranges care for the participant. They do not have to provide daily assistance. If a participant indicates a contact person in a backup plan who is not a paid caregiver, respite can be authorized.

5. Can a CDS attendant also provide respite for the same consumer through Agency Model?

Yes if the attendant is eligible for hire as an agency model attendant and there is unpaid caregiver that is being relieved. The CDS attendant may not provide to themselves.

6. Does the primary (unpaid) caregiver need to live with the participant?

A. With Basic Respite the unpaid caregiver does not have to reside in the home with the participant. However, with Advanced Respite the unpaid caregiver needs to reside in the home.

HCBS Policy Clarification Questions

Shared Living Spaces

1. What is a shared living space?
 - A. [19 CSR 15-8.100](#) defines unmet needs as “routine tasks and activities of daily living which cannot be reasonably met by members of the consumer’s household or other current support systems without causing undue hardship. A shared living space is considered a space requiring tasks such as cleaning that could reasonably be met by another able-bodied member of the consumer’s household who also uses that living space. HCBS are person-centered; therefore each participant’s living arrangements and unmet needs shall be taken into account to develop their care plan.
2. Are teenagers responsible for cleaning shared living spaces?
 - A. Minor children (under 18) should not be taken into account when developing the care plan with regard to shared living spaces. However, the authorized tasks should only be for the needs of the participant. For example, time would be authorized to clean the living room in its entirety; however time would only be authorized to wash dishes for the participant, not other members of the household.

HCBS Policy Clarification Questions

Electronic Visit Verification (EVV)

1. Can a participant refuse the use of an EVV system?
 - A. No. Neither the 21st Century Cures Act nor Missouri state regulation 13 CSR 70-3.320 provide opportunities for participants to opt out of utilizing EVV for personal care services.

2. Is there a list of EVV vendor companies that providers are able to select from?
 - A. The state of Missouri does not currently maintain a list of EVV vendors.

3. What are the requirements that EVV systems must meet?
 - A. Providers should refer to the 21st Century Cures Act as well as 13 CSR 70-3.320 to learn more about EVV technology requirements.

4. If there are two participants receiving services within the same household, can the aide use the same telephone number to report time for each participant?
 - A. Yes. Providers should refer to the 21st Century Cures Act as well as 13 CSR 70-3.320 to learn more about EVV technology requirements.

5. When using the Electronic Visit Verification (EVV) system is it necessary to print the system timesheet and have both the participant and aide sign it for accuracy?
 - A. It is not a requirement to get a signature when utilizing the EVV system; however, the provider must be able to produce EVV service reports upon the participant's request.

6. If the participant's landline or cell is not working properly, can the aide use their personal cell to clock in/out?
 - A. Yes, as long as the EVV technology in use meets the requirements outlined in the 21st Century Cures Act and 13 CSR 70-3.320.

7. If the aide forgets to clock out of the system, and the time is adjusted within the system and a comment is entered as to why the change was made, is it still necessary to have the aide/ participant sign a timesheet?
 - A. No, provided the EVV technology being used has the capability to enter a comment to explain the modification as described in this instance.

8. The Electronic Visit Verification (EVV) system I use allows the aide to clock in when their shift starts, clock out at the end of their shift and enter what tasks they delivered while they were working. Does this meet requirements?
 - A. All EVV technologies must meet the requirements outlined in the 21st Century Cures Act as well as 13 CSR 70-3.320.

HCBS Policy Clarification Questions

9. When utilizing Electronic Visit Verification System (EVV), the system records the exact minutes clocked in and out by the aide and the minutes do not equal full units. How do I bill for the extra minutes?
- A. The EVV regulation states: “In no way shall this rule prohibit the vendor/provider’s ability to accrue partial units pursuant to 13 CSR 70-91.” Partial units are often referred to as accrued minutes, rollover minutes, trimmed minutes, or other terms. Partial units are defined as the delivered minutes of a service that do not add up into a full billable unit of service. Please do not confuse this with rounding, which is a program violation. Partial units should be accrued and billed.

Example for accrual of partial units:

On February 3rd, the aide delivers 37 minutes of PC and 62 minutes of HC. On February 5th, the aide delivers 39 minutes of PC and 73 minutes of HC. On February 9th, the aide delivers 32 minutes of PC and 57 minutes of HC. On February 12th, the aide delivers 35 minutes of PC and 61 minutes of HC.

- The provider’s billing cycle is the 1st through the 15th of the month and the 16th through the last day of the month.
- In preparing the billing for Feb 1st through the 15th, the provider should bill:
 - $37 + 39 + 32 + 35 = 143$ minutes = 9 units and 8 minutes of PC. Provider should bill 9 units of PC for February 1st through the 15th, and 8 minutes may be accrued into the next provider billing cycle (through the end of the month).
 - $62 + 73 + 57 + 61 = 253$ = 16 units and 13 minutes of HC. Provider should bill 16 units of HC for February 1st through the 15th, and 13 minutes may be accrued into the next provider billing cycle (through the end of the month).

For those providers that do date specific billing, the “date of service” for billing purposes can be any date during the month. Two examples are given below.

Example 1 for providers who use Date Specific Billing: Date of Service is the date the partial unit becomes a full unit.

- On Monday, the aide delivers 37 minutes of PC and 62 minutes of HC. On Monday, the provider should have 2 units of PC and 4 units of HC to bill for on that date of service. The provider has accrued two partial units:
 - 7 minutes of PC and
 - 2 minutes of HC.
- On Wednesday, the aide delivers 39 minutes of PC and 73 minutes of HC. The provider should have 3 units of PC ($39 + 7 = 46 = 3$ units + 1 minute partial unit) and 5 units of HC ($73 + 2 = 75 = 5$ units) to bill for on that date of service. The provider has accrued 1 partial unit:
 - 1 minute of PC.

Example 2 for providers who use Date Specific Billing: Date of Service is the last date of the provider’s billing period.

HCBS Policy Clarification Questions

- On Monday, the aide delivers 37 minutes of PC and 62 minutes of HC. On Monday, the provider should have 2 units of PC and 4 units of HC to bill for. The provider has accrued two partial units:
 - 7 minutes of PC and
 - 2 minutes of HC
 - On Wednesday, the aide delivers 39 minutes of PC and 73 minutes of HC. The provider should have 2 units of PC and 4 units of HC to bill for. The provider has accrued 2 partial units:
 - 9 minutes of PC and
 - 13 minutes of HC
 - At the end of the provider's billing cycle, the provider should add all of their partial units (accrued minutes) for each service type together and bill for them. (Date of service should be the last date of the billing cycle).
10. Is it a requirement that a participant's EVV system connect with the MO HealthNet MMIS system for billing purposes?
- A. No, this is not a requirement at this time.
11. Is a participant permitted to clock in or clock out for their personal care aide/attendant using the aide/attendant's personal identification number (PIN) through EVV?
- A. It is not appropriate for a participant to have access to, or use, the personal care aide/attendant's PIN to clock in or clock out. An aide/attendant's PIN is unique, should not be shared, and is to be utilized to verify their presence at the time of service delivery
12. Missouri has indicated that it will be pursuing the development of an EVV aggregator in order to demonstrate compliance with upcoming CURES Act EVV requirements. What is an aggregator?
- A. Missouri has chosen to adopt a provider-choice model for EVV allowing providers to choose any qualifying EVV vendor. EVV vendors utilize a variety of different data formats. The state aggregator will compile the data from participating vendors and provide an overall summary of data. This data will be used to demonstrate Missouri EVV compliance to the Center for Medicare and Medicaid Services (CMS). The aggregated data will also be used by state agencies to ensure service delivery quality and identify any potential fraudulent activity. The aggregator vendor will work with each EVV vendor to ensure a variety of EVV solutions are successfully able to interface with the aggregator.
13. Are all personal care providers required to use EVV?
- A. No, Residential Care Facilities (RCFs), Assisted Living Facilities (ALFs), and Adult Day Cares (ADCs) are not required to use EVV.
14. Is it a requirement for EVV to be utilized for authorized nurse visits?
- A. No, EVV does not have to be used during authorized nurse visits.

HCBS Policy Clarification Questions

15. Is it a requirement for EVV to be utilized for provider reassessments?
 - A. No, EVV does not have to be used for provider reassessments.

16. Do EVV requirements apply if the individual receiving personal care lives with the caregiver providing the service?
 - A. Yes. Federal regulation offers states a choice in implementing EVV for services provided in these circumstances. Missouri has chosen to require EVV in these circumstances.

HCBS Policy Clarification Questions

Task	Basic Personal Care	Advanced Personal Care	Nursing Level of Care Tasks
Manual Assistance with self-administration of non-injectable medications	Opening medicine planner or bottles and guiding/ steadying participant's hand for oral medication and inhalants, oxygen and equipment – adding distilled water, changing tubing and cleaning equipment/ filter	Prompting participant, opening lockbox and guiding/steadying participant's hand for ear and eye drops, steady hand for pin-prick blood sugar monitor/PT INR and read levels	Filling the medicine planner/ administration of injectable medications, filling insulin syringes, administering blood sugar check or PT INR check finger prick tests
Catheter Hygiene	N/A	Emptying and changing the bag, cleaning (soap and water around catheter site) for indwelling or suprapubic catheters, removal/replacement of <u>external</u> (condom/Texas, etc.) catheters only	Catheter change of indwelling or suprapubic catheters.
Bowel Program	N/A	Enemas (prepackaged), sphincter stimulation, suppository administration for participants w/o contraindicating rectal or intestinal condition, Malone Antegrade Continence Enema (MACE) for well healed stomas	Administration of all other enemas, removal of fecal matter digitally
Central Line Care	N/A	N/A	Flushing lines, dressings, blood draws

HCBS Policy Clarification Questions

Task	Basic Personal Care	Advanced Personal Care	Nursing Level of Care Tasks
Ostomy Care- tracheostomies, gastrostomies and colostomies	N/A	Changing bags and/or wafer, and soap and water hygiene around a well healed ostomy site	Insertion of treatments or medications
Medicated lotion/ointment application	Application of nonprescription topical ointments or lotions	Application of prescription lotions, ointments and powders and/or dry aseptic dressings to unbroken skin (Stage I only)	Application of aseptic dressings to Stage II and above
Application of compression dressings/stockings	Application of Class I stockings/dressings	Lymphodema wraps and sleeves, and Class II dressings/stockings placement and removal of physician ordered orthotics.	Compression dressings/stockings higher than a Class II
Mobility/Transfer assistance	Assist with transfer/ambulation when participant able to bear most of their own weight, gait belt for mobility assistance	Use of assistive devices for transfer (participant able to bear little to no weight), including mechanical/Hoyer, sit-to-stand, slide board, sling, Barton chair, trapeze, gait belts and pivot discs	N/A
Passive Range of Motion (PROM)	N/A	With physicians order, flexion of joint within normal range	N/A
Bathing	Assist with bathing including shampooing of hair	N/A	N/A
Toileting/Contenance	Assist in transporting to/from restroom, changing of bed linens	N/A	N/A

HCBS Policy Clarification Questions

Task	Basic Personal Care	Advanced Personal Care	Nursing Level of Care Tasks
Dietary	Assist with meal prep/ clean up, and eating/ feeding, including participants requiring softened, pureed, liquid, or prep with a thickening agent for their diet	N/A	Tube feeding
Dressing / Grooming	Assistance in dressing/ undressing, combing hair, nail care, oral hygiene/ denture care, shaving, application of Class I compression stockings	N/A	Nail care for participants who are diabetic, prescribed anticoagulants, diagnosed with peripheral vascular disease or with a compromised immune system
Medically Related Household Tasks: Homemaker Services	Cleaning kitchen, bath, living areas, changing linens, laundry (home/off site), iron/mend, washing windows and blinds, trash, shopping/errands, essential correspondence	N/A	N/A