Par. 1. **Material Transmitted and Purpose --** Transmitted with this Manual Letter are changes to Service Chapter 535-05, Medicaid State Plan - Personal Care Services. The old language has been struck through and the revisions are in red and underlined.

Case Management 535-05-35

Case management for an individual applying for or receiving personal care services shall be the responsibility of a county social service board HCBS case manager except when the individual is also receiving a service(s) through the developmental disabilities division. Case management for personal care services for an individual receiving a service(s) through the DD division shall be the responsibility of a DD case manager. If the individual is not receiving service(s) through the DD Waiver, they have the right to choose the provider of case management services.

The case manager is responsible for assessing an individual's needs for personal care services, developing a comprehensive care plan that includes identification of tasks and times required to perform tasks, assisting the individual with obtaining a personal care service provider, monitoring and reassessing needs on a periodic basis, and terminating services when appropriate.

Decisions regarding personal care services for an incapacitated client are health care decisions that may be made pursuant to North Dakota Century Code section 23-12-13.

The applicant or guardian of the applicant shall provide information sufficient to establish eligibility for benefits, including a social security number, proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and such other information as may be required by this chapter for each month for which benefits are sought.

The case manager must schedule an appointment for an initial assessment no later than 5 working days after receiving a request for personal care services and must complete an initial comprehensive assessment no later

than 10 working days after receiving a request for personal care services. All contacts with an individual must be documented in the case file.

~~The case manager shall visit with an individual in his/her place of residence every six months and review and update the assessment and the individual's care plan as necessary.~~

An application for services must include a complete functional assessment that was conducted with the individual in the home where the individual resides by an HCBS Case Manager. A comprehensive assessment must be completed initially and annually thereafter for the individual or if there has been a significant change in personal care needs. The comprehensive assessment must include information on the individual's physical health, cognitive and emotional functioning, ability to perform activities of daily living or instrumental activities of daily living, informal supports, need for 24 hour supervision, social participation, physical environment, financial resources, and any other pertinent information about the individual or his/her environment.

Individuals must actively participate in the functional assessment to the best of their ability. Case Managers must document in the client narrative if there is a medical reason why the client cannot participate in the assessment or answer questions directly. If a third party (including family) reports that the client cannot participate in the assessment but the case manager questions if this information is accurate you may request medical documentation to confirm that the client is not capable of participating before you can establish eligibility. It is the responsibility of the client to provide all information necessary to establish eligibility per NDAC 75-03-23-15. Proof of blindness, disability and functional limitation may include but is not limited to complying with all requests for medical records or an evaluation from PT, OT, Speech, neuro-psych evaluation etc. that would assist the case manager in completing a determination for HCBS services.

After completing the comprehensive assessment, the case manager and individual work together to develop a plan for the individual's care based on the individual's needs, situations, and problems identified in the assessment. The individual and case manager work together to develop a comprehensive plan of care that is recorded in the individual's case file, authorized on the Authorization to Provide Personal Care Services SFN 663,

and summarized on the Personal Care Services Plan SFN 662. The plan must include:

1. All problems identified, including those that will not be addressed through the provision of personal care services.

2. Desired outcome(s) for each problem must be documented in the comprehensive assessment for which units of personal care services have been authorized.

3. The type(s) of help needed to achieve each desired outcome.

4. Services and providers that can supply the need for help.

5. Provider(s) the individual selects.

6. The amount of personal care service to be provided and the specific time-period.

7. Documentation of the medical necessity to monitor vital signs and identify who is to be notified of an individual's vital signs readings.

The case manager shall identify personal care service providers available to provide the service required by the individual and provide the following information to the individual:

1. Name, address and telephone number of available personal care service providers.

2. Identify whether a provider is an agency or individual QSP or a basic care assistance provider.

3. Any limitations applicable to the available providers.

4. If applicable, any global or individual specific endorsements for specialized cares that available providers are qualified to perform.

The individual must select the personal care service provider(s) they want to deliver the service to meet their care needs. The case manager must then complete an Authorization to Provide Personal Care Services, SFN 663, for each provider selected and finalize the Personal Care Services Plan, SFN 662.

The case manager must monitor and document that the individual is receiving the personal care services authorized on SFN 663. The case manager must review the quality and quantity of services provided. A reassessment of the individual's needs and care plan must be completed at a minimum of six-month intervals. The case manager shall visit with an individual in his/her place of residence every six months and review and update the assessment and the individual's care plan as necessary.

The case manager is responsible for following Department established protocols when abuse, neglect or exploitation of an individual is suspected.

Standards for Targeted Case Management (TCM) for persons in need of Long term Care.

- The service shall be performed by a social worker or agency who employs individuals licensed to practice social work in North Dakota and who has met all the requirements to be enrolled as either an Individual or Agency Qualified Service Provider (QSP) or an Indian Tribe/Indian Tribal Organization who has met State Plan requirements and requirements to be enrolled as a QSP or Developmental Disabilities Program Manager (DDPM) who is a Qualified Mental Retardation Professional (QMRP) or has one year experience as a DDPM with the Department.

The following enrolled provider types are eligible to receive payment for TCM:

- Case Managers employed by a County Social Service Agency who have sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled individuals.

- Developmental Disabilities Program Manager (DDPM) who is a Qualified Mental Retardation Professional (QMRP) or has one year experience as a DDPM with the Department.

- An Individual Case Manager or Agency Case Manager that has sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled individuals.

- Indian Tribe or Indian Tribal Organization who has met the provider qualifications outlined in the North Dakota State Plan Amendment

The following enrolled provider types are eligible to receive payment for TCM and Authorize MSP-PC Service:

- Case Managers employed by a County Social Service Agency (also eligible to approve services under SPED and EXSPED See Chapter 525-05-25).

- Developmental Disabilities Program Managers (DDPM)

    - If the client is a recipient of services funded by the SPED, Expanded SPED Programs, or MSP-PC the one case file will contain documentation of eligibility for TCM as well as for the service(s)

The following enrolled provider types are eligible to receive payment for single event TCM:

- County HCBS Case Managers, DDPMs, enrolled Individual or Agency Case Managers and enrolled Indian Tribe or Indian Tribal Organizations.

    - If the client requests a contact more than once every six months the Case Manager needs to obtain prior approval from a HCBS Program Administrator.

    - Indian Tribe or Indian Tribal Organizations are limited to providing TCM Services to enrolled tribal members.

<u>Targeted Case Management (TCM)</u>

The individual receiving TCM will meet the following criteria:

1. Medicaid recipient.

2. Not a recipient of HCBS (1915c Waiver) services.

3. Not currently be covered under any other case management/targeted case management system or payment does not duplicate payments made under other program's authorities for the same purpose

4. Lives in the community and desires to remain there; or be ready for discharge from a hospital within 7 days; or resides in a basic care facility; or reside in a nursing facility if it is anticipated that a discharge to alternative care is within six months.

5. Case management services provided to individuals in Medical institutions transitioning to a community setting. Services will be made available for up to 180 consecutive days of the covered stay in the medical institution. The target group does not include individuals between the ages of 22-64 who are served in Institutions for Mental Disease or inmates of public institutions.

6. Has "long-term care need." Document the required "long-term care need" on the Application for Services, SFN 1047. The applicant or legal representative must provide a describable need that would delay or prevent institutionalization.

7. The applicant or referred individual must agree to a home visit and provide information in order for the process to be completed.

Activities of Targeted Case Management

1-Assessment/Reassessment

2-Care Plan Development

3-Referral and Related Activities

4-Monitoring and Follow-up Activities

- The focus or purpose of TCM is to identify what the person needs to remain in their home or community and be linked to those services and programs.
- An assessment must be completed and a Care Plan developed. The client's case file must contain documentation of eligibility for TCM. The HCBS Comprehensive Assessment must be entered into the SAMS Web Based System or the THERAP System/MSP-PC Functional Assessment.
- Targeted case management is considered a "medical need" and thus included as a health care cost. Use of Medicaid funding for targeted case management may result in the recipient paying for/toward the cost of their case management. The client must be informed of that fact by noting Case Management Service and cost on the Individual Care Plan. Clients must also check and sign acknowledgment that if they are on Medicaid they may have a recipient liability. Payments from the Medicaid Program made on behalf of recipients 55 years or older are

subject to estate recovery including for Targeted Case Management.

- The case record must include a HCBS Comprehensive Assessment and narrative which includes:
    - Name of the individual,
    - Dates of case management service,
    - Name of the case management provider/staff.
    - Nature, content , units of case management service received, and whether goals specified in the plan are achieved
    - Whether the individual has declined services in the care plan
    - Coordination with other case managers,
    - TimeLine of obtaining services,
    - Timeline for reevaluation of the plan

Limits:

Case management does not include direct delivery of services such as counseling, companionships, provision of medical care or service, transportation, escort, personal care, homemaker services, meal preparation, shopping or assisting with completion of applications and forms (this is not an all-inclusive list).

Case file documentation must be maintained:

1. In a secure setting
2. On each individual in separate case files

If case management is not provided under any waivered service, Targeted Case Management must be identified on the Personal Care Services Plan, SFN 662.

An individual must be given annually a "Your Rights and Responsibilities" brochure, DN 46 (available through Office Services), and verification of receipt of the brochure must be noted on SFN 1047, Application for Services, or in the documentation of the assessment.

Rural Differential Rates 535-05-38

NEW SECTION

Purpose

The purpose of the rural differential rate is to create greater access to home and community based services for clients who reside in rural areas of North Dakota by offering a higher rate to QSPs who are willing to travel to provide services. QSPs that are willing to travel at least 21 miles round trip to provide care to authorized individuals in rural areas will be reimbursed at a higher rate for those cares. QSPs are not paid for the time they drive to or from the client's home; the rural differential rate may only be used for the time spent actually providing services.

Standards for Providers

Enrolled agency or individual QSPs, authorized to provide Medicaid State Plan Personal Care Services.

Service Activities, Authorized

The rural differential rate must be identified on the Personal Care Service Plan, SFN 662 and the Authorization to Provide Personal Care Services, SFN 663. The SFN 662 and SFN 663 must be sent to the HCBS State office for all cases where the rural differential has been authorized. The SFN 663 must also include the clients physical address (PO Box is not acceptable). A printed copy of the map quest results must be maintained in the clients file, and send into the HCBS State office. If more than one provider is authorized and not all have Rural Differential Rate or different Rural Differential Rates a separate SFN 663 must be completed for each rate.

Service Eligibility, Criteria for

An HCBS client receiving services paid at the rural differential rates will meet the following criteria:

1. Must be eligible for Medicaid State Plan personal Care (MSP-PC).

2. Reside outside the city limits of Fargo, Bismarck, Grand Forks, Minot, West Fargo, Mandan, Dickinson, Jamestown, and Williston.

    - Situations where there is a discrepancy in what is considered city limits must be prior approved by the Rural Differential Coordinator. The HCBS Case Manager must send a written request for verification to the HCBS Program Administer responsible for program oversight.

3. Needs personal care and does not have access to a QSP of their choice, within 21 miles of their residence that is willing to provide care.

Service Delivery

The rural differential rate is based on the number of miles (round trip) a QSP travels from their home base to provide services at the home of an authorized HCBS recipient.

- Home base is either the individual QSPs physical address, or the Agencies home office, satellite office, or employees physical address (if they are not required to report to the home office each day because of distance) whichever is closer.

- If an agency employee is not required to report to the home office each day because of distance and they live 21 or more miles (round trip) from the client's home the rural differential rate may be used. If the employee lives less than 21 miles (round trip) from the client's home than the rural differential may not be used.

- Rural differential rates are based on the distance it takes to travel to each individual client's home even if the QSPs serve more than one recipient in the community or in the same home.

Addresses:

Case Managers must use the physical address (PO BOX is not acceptable) listed on the QSP list when determining which rural differential rate to use for individual QSPs and Agency providers. A QSP list including the provider's physical addresses will be provided to the HCBS Case Managers monthly.

Agency employees who are not required to report to their agency each day because of distance must make their address available to the HCBS office for verification. This address must be entered on the SFN 663 under QSP

physical address. If a QSP states that the physical address on the QSP list is incorrect they must contact the HCBS office to change it before an authorization can be provided that includes a rural differential rate. It is not sufficient to notify the case manager.

If the QSP's address changes, the provider must notify HCBS and their Case Manager within 14 days. Once the Case Manager receives a notification of address change, they must recalculate a Map Quest to determine if there are any changes to Rural Differential eligibility for the QSP.

If the QSP's new address does not change the tier they have previously been approved for, the Case Manager must only make corrections to the authorization and Map Quest. A copy of the unchanged care plan, updated authorization and Map Quest must be forwarded to the Department. In addition, a copy of the revised authorization must be forwarded to the QSP.

If the address change does affect the tier previously authorized, the Case Manager must make corrections to the care plan, authorization and Map Quest and send to the Department. A copy of the revised authorization must also be forwarded to the QSP.

If the QSP no longer qualifies for an RD rate, the Case Manager must update the SFN 662 and SFN 663 by putting the DATE RD Removed on both forms and submit the SFN 662 and 663 with the state. The updated SFN 663 must be sent to the QSP.

Forms 535-05-70

Instructions for Completing Personal Care Services Plan, SFN 662 535-05-70-01

The Personal Care Services Plan (PCSP) SFN 662 documents the eligibility for personal care services and the amount of personal care services that will be provided to an eligible individual and the provider(s) selected by the individual to perform the services. The PCSP is required for all individuals assessed or receiving personal care services and is the outcome of the initial comprehensive assessment, annual assessment, or six-month review of the individual's needs. No payment may be made to any provider until the PCSP is filed with the state office. A copy of all Authorizations to Provide Personal Cares Services SFN 663 must accompany the PCSP filed with the state office.

The PCSP is to be revised or updated as an individual's needs require. At a minimum it must be reviewed with the individual six months following an initial or annual assessment. The PCSP must be revised every time the individual's service needs change or when a change in service provider(s) occurs.

The individual's case manager must complete the PCSP in conjunction with the individual or his/her legal representative. The signature of the individual or the legal representative on the PCSP is required before services can be authorized for payment. If the individual or legal representative refuses to sign the PCSP, the reason for the refusal must be noted in the case file. Any changes or revisions to a PCSP require the signature of the client with the exception of a change in provider. When a change in service provider occurs between case management contacts -- the client or legal representative may contact the case manager requesting the change in provider. The contact and approval for the change in provider must be verified in the case manager's documentation and noted on the PCSP which is sent to the Department. A copy of the updated care plan must be sent to the client or legal representative. However, changes in services, which include tasks, or the amount of service, which includes amount of units authorized for each task, must be signed by the client or legal representative and approved.

Section I – Client Information

Enter the individual's name, address, Medicaid number, county of residence, ~~and the~~ date the comprehensive assessment is completed and the date the LOC was determined.

A LOC determination approval must be obtained whenever an individual has not had any LOC determination approved within 12 months of the start of a care plan period. If the individual does not meet NF or ICF/MR level of care then check PCS-A. The date of the next LOC determination is the responsibility of the case manager and needs to be scheduled to allow sufficient time in which to give the client a ten working day notice should personal care services be reduced because the individual no longer meets the criteria for LOC.

Instructions For Obtaining ICF/MR Level Of Care (LOC) Determination (for use by DD case managers)

An individual in need of Level B or Level C personal care services must have an ICF/MR LOC determination done whenever a comprehensive needs assessment is completed.

Individuals eligible to meet the ICF/MR level of care include individuals with a diagnosis of mental retardation as defined in NDAC 75-04-06 or persons with related conditions as defined in 42 CFR 435.1009.

The developmental disabilities case manager must complete a comprehensive needs assessment to determine whether the individual meets the minimum criteria for the ICF/MR level of care. The application of the Guidelines for ICF/MR level of care screening serve as the basis as to whether the individual qualifies for Level B of Level C personal care services.

Instructions For Obtaining Nursing Facility (NF) Level Of Care Determination

An individual in need of Level B or C personal care services who does not meet ICF/MR level of care criteria must have a NF level of care determination approved within 12 months of the start of any personal care service plan. The date of the next NF level of care determination is the responsibility of the case manager and needs to be scheduled to allow sufficient time in which to give the client a ten working day notice should personal care services be reduced or terminated.

The case manager shall use the existing and established procedures for requesting a NF level of care determination from Dual Diagnosis Management (DDM). The information needed for submission of information to DDM is usually obtained during the comprehensive needs assessment process.

It is the responsibility of the case manager to trigger the screening by submitting information to DDM. The basis of the information submitted is verified and documented in the completion of the materials identified in items 1 and 2 below. Item 2 below is the ONLY document that needs to be submitted to DDM.

1. The comprehensive needs assessment

2. ND LEVEL OF CARE/Continued Stay Review Determination Form

You are encouraged to submit by web based method; however you may fax the information.

Following are the screen types listed on the LOC Determination Form.

- MSP-PC
- HCBS Waiver/MSP-PC (check only if eligible for both)

DDM will send written confirmation of NF level of care determination to the case manager for filing in the client's record.

If you are unable to resolve NF determination issues with DDM, contact the Administrator of Long Term Care Projects at 328-2321.

Section II – Eligibility for Personal Care Service

Score the individual's needs in accordance with the instructions for scoring ADLs and IADLs to determine if the individual qualifies for personal care services. Narratives in the individual's file must verify the rationale for each score, and the determination for eligibility. Client must be scored impaired in the ADL or IADL before it can be authorized

Choose the level of personal care needed based on the eligibility criteria outlined in Personal Care Eligibility Requirements 535-05-15.

Determine the type of provider that will be providing services based on the individual's choice.

Check/complete the appropriate box:

PCS-A

PCS-B

PCS-C

~~LOC Determination Date~~

Daily

~~PCS~~ Basic Care

~~None~~

~~A LOC determination approval must be obtained whenever an individual has not had any LOC determination approved within 12 months of the start of a care plan period. If the individual does not meet NF or ICF/MR level of care then check PCS-A. The date of the next LOC determination is the responsibility of the case manager and needs to be scheduled to allow sufficient time in which to give the client a ten working day notice should personal care services be reduced because the individual no longer meets the criteria for LOC.~~

If the individual chooses to receive services on a daily rate (T1020), the "Daily" check box must be checked. To determine the Daily rate send a completed SFN 662 and 663 to Medical Services and the rate will be calculated by Medical Services. The provider and case manager will receive a copy of a profile that documents the rate. The daily rate needs to be recalculated whenever there is an increase or decrease in units of service approved for a client.

~~If the individual does not qualify for personal care services, check NONE (provide the client with a formal Denial and completed SFN 1647) and skip to Section V Signatures.~~

~~*Instructions For Obtaining ICF/MR Level Of Care (LOC) Determination (for use by DD case managers)*~~

~~An individual in need of Level B or C personal care services must have an ICF/MR LOC determination done whenever a comprehensive needs assessment is completed. The date of the next ICF/MR LOC determination is the responsibility of the case manager and needs to be scheduled to allow sufficient time in which to give the client a ten working day notice should personal care services be reduced because the individual no longer meets the criteria for Level B or C services~~.

~~Individuals eligible to meet the ICF/MR level of care include individuals with a diagnosis of mental retardation as defined in NDAC 75-04-06 or persons with related conditions as defined in 42 CFR 435.1009.~~

~~The developmental disabilities case manager must complete a comprehensive needs assessment to determine whether the individual meets the minimum criteria for the ICF/MR level of care. The application of~~

~~the Guidelines for ICF/MR level of care screening serve as the basis as to whether the individual qualifies for Level B personal care services.~~

~~*Instructions For Obtaining Nursing Facility (NF) Level Of Care Determination*~~

~~An individual in need of Level B or C personal care services who does not meet ICF/MR level of care criteria must have a NF level of care determination approved within 12 months of the start of any personal care service plan. The date of the next NF level of care determination is the responsibility of the case manager and needs to be scheduled to allow sufficient time in which to give the client a ten working day notice should personal care services be reduced or terminated.~~

~~The case manager shall use the existing and established procedures for requesting a NF level of care determination from Dual Diagnosis Management (DDM). The information needed for submission of information to DDM is usually obtained during the comprehensive needs assessment process.~~

~~It is the responsibility of the case manager to trigger the screening either by telephoning DDM or by submitting information to DDM. The basis of the information submitted is verified and documented in the completion of the materials identified in items 1 and 2 below. Item 2 below is the ONLY document that needs to be submitted to DDM.~~

~~3. The comprehensive needs assessment~~
~~4. ND LEVEL OF CARE/Continued Stay Review Determination Form~~

~~You are encouraged to submit by web based method; however you may fax the information or do a telephone determination. Before conducting the telephone determination with DDM you must have completed DDM's ND LEVEL OF CARE/Continued Stay Review Determination Form. This includes having the client's Medicaid ID number. DDM will not process the determination without having the client's Medicaid ID number. When conducting a telephone determination, you must have the written materials on file in the client's case record for verification of the basis of the information transmitted in the telephone determination. Check the appropriate screen type.~~

~~Following are the screen types listed on the LOC Determination Form.~~

~~• MSP-PC~~

~~• HCBS Waiver/MSP-PC (check only if eligible for both)~~
~~• MSP-PC/SPED under age 18. (Check only if eligible for both)~~

~~Upon completion of the NF level of care determination, DDM will submit to Claims Processing, Medical Services a list of the recipients, with the approval or effective date of eligibility, ID Number, and date of birth. DDM will also send written confirmation of NF level of care determination to the case manager for filing in the client's record.~~

~~When requesting a determination by mail, send only DDM's ND LEVEL OF CARE/Continued Stay Review Determination. The form is to be mailed to:~~

~~Dual Diagnosis Management~~

~~227 French Landing Drive, Suite 250~~

~~Nashville, TN 37228~~

~~Telephone number (877) 431-1388~~

~~Fax number (877) 431-9568~~

~~When requesting a determination by telephone, it is not necessary to mail any forms to DDM. However, whether the case manager chooses to complete the screening by mail, fax, or telephone, the items identified previously as 1) and 2) must be contained in the case file prior to any contacts with DDM.~~

~~If you are unable to resolve NF determination issues with DDM, contact the Administrator of Long Term Care Projects at 328-2321.~~

If any of the QSPs are eligible for Rural Differential Rate check the appropriate RD boxes. When a QSP is no longer receiving rural differential for this client complete Date RD removed and submit the SFN 662 and SFN 663 to Medical Services and the QSP. See Rural Differential Rates 535-05-38.

Section III – Approved Services

For QSPs who will be paid based on 15 minute unit rate basis, enter the personal care service provider name, provider number, the units authorized on SFN 663, the 15-minute (T1019) procedure code, and the billable units (units will be the same as the authorized units) to be provided on a monthly basis. If multiple providers are listed on SFN 663 list all providers and provider numbers but complete only 1 line for authorized units, procedure code, and billable units. The procedure code for services

must be T1019. The total number of units of service to be provided per month by all providers based on 15-minute increments must be entered. The total number of units per month for procedure code T1019 may not exceed 480 units if PCS – A is checked or 960 units if PCS – B is checked or 1200 units if PCS-C is checked.

For a QSP who elects to be paid a daily rate, enter the personal care service provider name, provider number, the authorized units from SFN 663, the per day (T1020) procedure code, and 31 in the billable units/day column. The procedure code for personal care services provided on a daily basis must be T1020. When the care plan is filed with the state, the daily rate will be calculated by the state office and the provider will be notified of the daily rate. In no case may a daily rate exceed the daily rate limit set forth in the state plan.

If personal care services are to be provided by a basic care assistance provider, enter the provider name, and provider number.

- If the basic care assistance provider is to be paid based on a daily rate, enter the units authorized on SFN 663 in the authorized units column, enter 4 in the procedure code column, and 31 in the billable units/days column. Eligibility for daily rate requires the client receives a daily services in at least one of the Task Categories listed on the SFN 663 of ADL, Meal Prep, Med Assistance or Other on a daily basis.

- If the basic care assistance provider is to be paid based on a 15 minute increment rate enter the units authorized on SFN 663 in the authorized units column, T1019 in the procedure code column, and the authorized units in billable units/days column (units will be the same as the authorized units) to be provided on a monthly basis.

Section IV - Other Services

Record services which are not authorized as personal care services but are being provided or arranged for the individual. This section should include services such as home health, home delivered or congregate meals, transportation, SPED, EXSPED, waivered services, or family support services.

Section V – Signatures

The instructions for the completion of a reduction is outlined in Denials, Terminations, and Reductions 535-05-50

If the care plan for personal care services expires or services are terminated and a new care plan is not going to be issued, you must follow the policy for Termination. Complete the date of case closure and reason for case closure and submit to the client and Department and a copy of the canceled authorization SFN 663 to the client provider, and Department.

If a care plan for personal care services is being terminated prior to the end of the effective date of the plan and a new care plan is being issued send a copy of the canceled care plan SFN 662 to the client and Department and a copy of the canceled authorization SFN 663 to the client, provider, and Department. The instructions for the completion of a Termination are outlined in Denials, Terminations, and Reductions 535-05-50.

If the individual was determined not to qualify for personal care services in Section II, then the individual must be informed of their rights. The instructions for the completion of a Denial is outlined in Denials, Terminations, and Reductions 535-05-50.

If the client is not in agreement with the PCSP, they should enter their initials indicating they are not in agreement with the plan of care. The Case Manager must provide the client with a completed SFN 1647, (Reduction, Denial, or Termination Form).

The individual (or the individual's legal representative) and the case manager both must sign to signify agreement with the PCSP. If the individual refuses to sign the PCSP, the case manager must provide the client with a completed SFN 1647 and a copy of the unsigned plan must be forwarded to the state office.

If a care plan changed due to a change such as; a change in provider, or change in units approved, or other change prior to the end of an existing care plan period, check the reason for the change and describe if appropriate. Then send a copy of the canceled and updated care plan SFN 662 to the client and Department and send copy of the canceled and updated SFN 663 to client, provider, and Department.

The case manager should check the appropriate identification of the program case management, DDCM for Developmental Disabilities Case Manager or HCBS ~~CM~~ for Home and Community Based Waiver Case Manager.

Section VI – Six-Month Review and Continuation of Plan with No Changes

The case manager may complete this section only if no change in the individual's status, authorized units, and provider(s) occurs at the six-month review or 3 month review for Level C Personal Care. The case manager must enter the new effective date continuing the plan for the next period that may not exceed 6 months or 3 months for Level C Personal Care. The case manager and the individual both must sign for the continuation of the plan.

Distribution

The original PCSP and any changed PCSP is filed in the individual's case file. One copy is mailed or given to the individual or the legal representative when completed. A copy of SFN 662 and a copy of SFN 663(s) must be mailed within 3 days of completion to the respective state office (Developmental Disabilities or Medical Services).

The SFN 662 is available from Office Services and an electronic copy is available through the state e-forms.

Instructions for Completing the Authorization to Provide Personal Care Services, SFN 663 535-05-70-05

The Authorization to Provide Personal Care Services SFN 663 is used to grant authority to a qualified service provider or basic care assistance provider for the provision of agreed upon service tasks to an eligible individual.

The Authorization to Provide Personal Care Services is completed when arrangements are being made for the delivery of personal care as agreed to in the individual's Personal Care Services Plan. The individual must have an identified need for the services in order to be authorized to receive the services. For example, if an individual is not identified on the PCSP as

being impaired in bathing, no authorization can be given for a provider to assist the individual with bathing.

The case manager must complete an Authorization to Provide Personal Care Services for all providers, including basic care assistance providers, selected by the individual to perform personal care services. If personal care services are to be provided by multiple providers, without specific identification of authorized services to each provider, only one SFN 663 is completed and each provider must receive a copy of the SFN 663. The use of one form for multiple providers may only be used if all providers are authorized to perform the same tasks. The case manager must determine that the provider(s) the individual has selected is available and when service(s) will begin.

Enter the name, ~~and~~ Medicaid provider number of the personal care service provider(s), and Physical Address in the "Qualified Service Provider(s) Name and Number" block. If the provider is a basic care provider enter the date the individual was admitted or is anticipated to be admitted to the facility in the "Date of Admit to Basic Care" block.

Enter the client's name, Medicaid ID number, physical address, and telephone number, in the applicable blocks.

"Authorization Period" - Identify the period of time the authorization is in effect. The authorization period MAY NOT exceed six (6) months or 3 months for Level C Personal Care, except for an initial authorization which can include a partial month in excess of 6 months. Renewal of the authorization should coincide with the 6-month Review or Annual Reassessment. The authorization period should begin on the first of a month, except if this is an initial authorization for personal care services for an individual or if a change in status or provider occurs, and must end on the last day of a month.

"Six Month Review Authorization Period" - this section is to be completed at the six month or 3 month for Level C Personal Care review only if there is no change from the existing authorization in the amount of units, tasks, or providers. Identify the additional period of time the existing authorization is to be in effect. The additional authorization period MAY NOT exceed six (6) months or (3) three months for Level C Personal Care.

"Total Authorized Units" – enter the total units authorized to be provided, this includes the total of the units approved in the Authorized Units per Task Category behind the correct procedure code. If the procedure code is T1020 (Daily Rate) complete the per day rate/cost.

"Authorized Units per Task Category" - enter the total authorized units of service based on 15-minute increments for each personal care services tasks authorized under ADL - activities of daily living, Meal Prep -meal preparation, Med Assist – medication assistance, Ldry/Shp/Hskp - laundry, shopping, housekeeping, and Other. Total of the five subgroups must equal total authorized units. NOTE: Total authorized housekeeping, laundry, and shopping units of service may not exceed 30% of the total units of all personal care services authorized for the client. Authorized units must be supported by documentation in the individual's case file.

- Some flexibility is anticipated in the provision of tasks amongst the categories of ADL, Other, Meal Prep, and Med Assist and the provider is allowed to bill up to the total units approved in these 4 categories; however, the provider may not bill for units in excess of the units authorized in the category of Ldry/Shp/Hskp.

- A written, signed recommendation for the task of vital signs provided by a nurse or higher credentialed medical provider must be on file that outlines the requirements for monitoring, the reason the task is required and frequency. When the tasks of Temp/Pulse/Respiration/Blood Pressure are authorized, the individual to be contacted for readings must be listed on the SFN 633.

- For the task/activity of exercise a written recommendation and outlined plan by a therapist for exercise must be on file. Exercise is limited to maintain or improve physical functioning that was lost or decreased due to a injury or a chronic disabling condition (i.e., multiple sclerosis, Parkinson's, stroke etc.). Exercise does not include physical activity that generally should be an aspect of a wellness program for any individual (i.e., walking for weight control, general wellness, etc.).

- For individuals receiving Personal Care Services in a Basic Care setting, enter ADL, Meal Prep and Medication Assist to verify the daily

rate. Do not need to identify units for laundry, shopping and housekeeping.

In addition, prior authorization from a State HCBS or DD Program Administrator is required to authorize units for meal prep, laundry, shopping, and housekeeping when performed by a live in provider or for a client who lives with other capable persons. Prior authorization must be renewed annually.

"Personal care services tasks authorized" - check the specific service tasks to be completed by the personal care service provider(s). The explanation of tasks found on the back of the Authorization to Provide Personal Care Services should be referenced in defining the parameters of the service tasks. Include the amount of units that are authorized for each task. If use of a daily rate is authorized, 1 or more of the tasks of dressing/undressing, feeding, incontinence, inside mobility, toileting, transferring/turning/positioning, meal preparation, and medication assistance must be needed and provided on a daily basis.

The activities and tasks identified as global endorsements may be provided only by a personal care service provider who has demonstrated competency and carries a global endorsement. Review the QSP list to determine which global endorsements the provider is approved to provide.

Activities and tasks authorized as a client specific endorsement may be provided only by a personal care service provider who has demonstrated competency and carries a client specific endorsement to provide the required care within the identified limitations. The case manager must obtain from the QSP, a completed SFN 830, Request for Client Specific Endorsement. A copy of SFN 830 must be included in the individual's file, and a copy sent to Medical Services.

Check the appropriate Rural Differential Rate if applicable. Include the unit rate that is authorized. Note: If more than one provider is authorized and not all have Rural Differential Rate or different Rural Differential Rates a separate SFN 663 must be completed for each rate.

When a QSP is no longer receiving rural differential for this client complete Date RD removed and submit the SFN 662 and SFN 663 to Medical Services and the QSP. See Rural Differential Rates 535-05-38.

The case manager must sign and date the form to officially authorize, reauthorize, or cancel the personal care services. The only time an authorization to provide service is not canceled is when the service period expires.

Distribution

The original and any changed Authorization to Provide Personal Care Services is given to each personal care service provider(s) and a copy of the form is filed in the individual's case record, and a copy is provided to the individual or legal representative, and a copy is sent to the appropriate State Office.

The SFN 663 is available from Office Services and an electronic copy is available through the state e-forms.

HCBS Case Closure/Transfer Notice or Request for HCBS NF Determination, SFN 474 535-05-70-13

NEW SECTION

Purpose: To notify Medical Services/HCBS an MSP-Personal Care case was transferred to another county.

When prepared:

This form is to be completed for transfers related to MSP-Personal Cares. Do not submit to close a MSP-Personal Case.

Steps of Completion:

In the first section, **always** complete the County name and Case Manager Section. Also complete the Client Name: Record the first and last name

ID Number: Record the Medicaid recipient identification number.

Indicate on the form that this is a MSP-Personal Care case.

Transfer Case to Another County Section: Print the client's last, first, and middle (initial) name; record the applicable ND identification number, the receiving county name, and the client's new address (if known).Enter the date client is leaving current county and date client is entering new county.

The new HCBS Case Closure/Transfer Notice is due to Medical Services/HCBS within 3 working days from the date the County is made aware that the case is transferring to another County.

This form is not available from the state office. It is electronically available through the state's e-forms.