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

Par. 2. **Effective Date** – January 1, 2024

Personal Care Eligibility Requirements 535-05-15

(Revised ~~2/1/17~~ 01/01/2024 ML #~~3489~~ 3795)

To qualify for coverage of personal care services, an individual must have applied for and been found eligible for Medicaid benefits

And

1. Eligibility criteria for **Level A (up to 480 units per month), or Daily Rate care, or Basic Care** includes:

    1. Be impaired in at least one of the following ADLS of:

        1. Bathing
        2. Dressing
        3. Eating
        4. Toileting
        5. Continence
        6. Transferring
        7. Inside Mobility

    Or

    b. Be impaired in at least THREE of the following IADLs:

        a. Meal Preparation
        b. Housework
        c. Laundry

d. Taking medications

2. Eligibility for **Level B (up to 960 units per month)** includes:

a. Be impaired in at least one of the following ADLS of:

a. Bathing

b. Dressing

c. Eating

d. Toileting

e. Continence

f. Transferring

g. Inside Mobility

Or

b. Be impaired in at least THREE of the following IADLs:

a. Meal Preparation

b. Housework

c. Laundry

d. Taking medications

AND

c. Meet the nursing facility level of care criteria set forth at NDAC 75-02-02-09 or meets ICF/MR level of care criteria.

3. Eligibility for Level C (up to 1200 units per month) includes:

a. Be impaired in at least five of the following ADLS of:

a. Bathing

b. Dressing

c. Eating

d. Toileting

e. Continence

f. Transferring

g. Inside Mobility

AND

b. Meet the nursing facility level of care criteria set forth at NDAC 75-02-02-09 or meets ICF/MR level of care criteria.

AND

c. None of the 300 hours (1200 units) approved for personal care services can be allocated to the tasks of laundry, shopping, or housekeeping.

AND

d. Have written prior approval for this service from a HCBS Program Administrator, Aging Services Division, Department of Human Services. The approval must be updated every ~~three~~ six months.

After completing a comprehensive needs assessment the individual's case manager shall complete Section II of Personal Care Services Plan, SFN 662, to determine if the individual qualifies for personal care services. Section II allows the case manager to determine the level of impairment an individual is experiencing, based on specific medical, emotional and cognitive status. An individual must be impaired (have a score of at least 2) for any 1 ADL, or impaired (a score of at least 1) in 3 of the 4 IADLs meal preparation, housework, laundry, or taking medications. See the Instructions for Completing the Functional Assessment on scoring ADLs and IADLs.

The assessment measures the degree to which an individual can perform various tasks that are essential to independent living. Information on each of the ADLs or IADLs can be collected by observation, by direct questioning of the individual, or by interview with a significant other. The case manager shall maintain documentation supporting the level of impairment and shall include the following information if applicable:

1. Reason for inability to complete the activity or task
2. Kind of aid the individual uses (e.g., a grab bar or stool for bathing)
3. Kind of help the individual requires (e.g., preparing the bath, washing back and feet, complete bed bath) and the frequency of the need to have the help (e.g. units of services needed)
4. Who provides the help
5. Reasons for inability of a spouse or parent of a minor child to perform the activity or task for the individual
6. The individual's health, safety and welfare needs that need to be addressed
7. Document the anticipated outcome as a result of service provision
8. Other pertinent information

A comprehensive assessment must be completed initially before any personal care services can be authorized and annually thereafter. A review of the individual's needs must be completed every six months or when there is a significant change in the individual's needs.

Limitations and Non-covered Services 535-05-25

(Revised ~~2/1/17~~ 01/01/2024 ML #~~3489~~ 3795)

1. Personal care services may not include skilled services performed by persons with professional training.
2. An individual receiving personal care services may not be an inpatient or resident of a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, a psychiatric residential treatment facility, or an institution for mental disease.
3. Personal care services may not include home delivered meals; services performed primarily as housekeeping tasks; transportation; social activities; or services or tasks not directly related to the needs of the individual such as doing laundry for family members, cleaning

of areas not occupied by the individual, or shopping for items not used by the individual.

4. Meal preparation is limited to the maximum units set by the department. Laundry, shopping, and housework tasks when provided must be incidental to the provision of other personal care tasks and cannot exceed 30% of the total time authorized for the provision of all personal care tasks. Personal care service tasks of laundry, shopping, and housekeeping are limited to the maximum units set by the department, and the cap cannot be exceeded under other home and community-based services funding sources.

5. Services provided by a spouse, parent of a minor child, or legal guardian are not covered.
6. Effective 1/1/2021 ~~P~~payment for the tasks of laundry, shopping, housekeeping, meal preparation, money management, and communication ~~cannot be made to~~ requires prior approval for a provider who lives with the ~~client~~ individual ~~and is a relative listed under the definition of family home care under subsection 4 of North Dakota Century Code section 50-06.2-02 or is a former spouse.~~
    - The above tasks may be assessed for individuals whose provider is a relative listed under the definition of family home care under subsection 4 of the North Dakota Century Code section 50-06.2 02 or who is a former spouse beginning at the first required contact after 1/1/2021.
    - Prior approval will only be granted for environmental tasks and/or meal preparation when the service exclusively benefits the consumer.
    - Conditions that would exclusively benefit the consumer would include, but are not limited to, maintenance of non-shared spaces, completion of laundry if there is a documented reason it must be completed separately for instance frequent incontinence, and/or authorization of pureeing food or preparing a liquid diet.

7. Care needs of the individual that are outside the scope of personal care services are not covered.

8. Services provided in excess of the services or hours authorized by the case manager in the individual's approved service plan are not covered.

9. Authorized personal care services may not exceed 120 hours (480 units) per month for Level A Personal Care Services or 240 hours

(960 units) per month for Level B Personal Care Services, and 300 hours (1200 units) per month for Level C Personal Care Services.

10. Personal care services may only be provided when the needs of the eligible individual exceed the abilities of a spouse or parent(s) of a minor child to provide such services. Personal care services may not be substituted when a spouse or parent(s) of a minor child refuses or chooses not to perform the service. Personal care services may be provided during periods when a spouse or parent(s) of a minor child is gainfully employed if such services cannot be delayed until the spouse or parent(s) is able to perform them.

11. Personal care services may not be provided for tasks that are otherwise age appropriate or generally needed by an individual within the normal stages of development.

12. Per guidance given by the Centers for Medicare and Medicaid Services in the following 2001 HHS Survey and Certification memo, personal cares can be offered in conjunction with Hospice services.

    https://www.cms.gov/Medicare/Provider-Enrollment-and Certification/SurveyCertificationGenInfo/downloads/SCLetter01-013.pdf

13. The combination of personal care services and hospice service requires ~~prior~~ approval from the Department. The request must outline the client's needs, the services that will be provided through Hospice, and the services being requested through MSP PC. The request must also contain an assurance that there is not a duplication of services.

14. The Hospice plan of care must include the need for personal care services and a copy must be maintained in the client's file.

Prior Authorization 535-05-30

(Revised ~~2/1/17~~ 01/01/2024 ML #~~3489~~ 3795)

Prior authorization by a case manager is required for all personal care tasks provided to an individual who meets the qualifying criteria for personal care services. The case manager must complete Personal Care Services Plan SFN 662 (PCSP) authorizing the services and hours that may be provided per month. Services and hours may be authorized for a period not to exceed 6 months.

The case manager must submit SFN 662 and supporting SFN 663(s) to either Aging Services or the Developmental Disabilities Division within three (3) working days of the date of completion of an assessment. Payment for personal care services may not be made without a prior authorization. With the exception of the authorization of Personal Care Services to be provided in a basic care facility, Personal Care Services may not be authorized prior to the date of the assessment. Authorization of Personal Care Services in a basic care facility may be authorized or up to 10 working days prior to the date of the assessment.

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. ~~Authorizations must be renewed annually.~~ A request must be sent to the program administrator annually that outlines the following:

1. The reason the consumer is impaired.

2. The tasks to be authorized.

3. Narrative explaining how the completion of the task(s) will benefit the consumer exclusively, i.e. the task is for a non-shared area, frequent incontinence requires the consumer's laundry to be washed separately.

Case Management 535-05-35

(Revised ~~2/1/17~~ 01/01/2024 ML #~~3489~~ 3795)

Case management for an individual applying for or receiving personal care services shall be the responsibility of an ~~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.

Part of completing an assessment includes determining an individual's overall support needs, whether the supports will be provided through HCBS or through other community resources. To coordinate services for a client, case managers

may need to make referrals and gather other collateral information. Not all communication requires a release of information, for example, case managers can share client information with health care professionals working in the following settings: home health care, hospitals, clinics, PACE, and LTC facilities, as this communication is part of the continuum of care guidelines under HIPAA. Case Managers can also share information with other case management entities (i.e. DD, VR, behavioral health) within the Department of Human Services, as well as eligibility workers under the Medical Services Division. Information shared without a release of information must be on a need-to-know basis to coordinate care for the client, disclosing only the minimum necessary amount of information pursuant to 45 CFR 164.502(b). Disclosure of information related to psychological or substance abuse treatment requires that the client sign a release of Information.

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.

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.

A quarterly face-to-face visit is required for consumers receiving services under Level C. At each quarterly contact, the case manager will monitor the quality, quantity and frequency of services, assess and/or review any risks, and monitor all health/welfare/safety concerns. A narrative must be completed for each quarterly contact.

The State Medicaid Agency may waive the face to face requirement for case management services, based on specialized health care situations that may require a recipient to be out of state for other medical services. Any waiver of this requirement will require special approval from the HCBS Program Administrator.

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 Developmental Disability Professional (QDDP) 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 Developmental Disability Professional (QDDP) 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

(Revised ~~2/1/17~~ 01/01/2024 ML #~~3489~~ 3795)

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.

All individual QSPs and agency employees that are authorized to bill using the rural differential rate will be required to submit proof of address upon request to Medical Services Home and Community Based Services. The only proof of address that will be accepted for North Dakota residents will be a valid North Dakota driver's license. Once the driver's license is received the Department will verify that the address is current with the Department of Transportation.

If the QSP or agency employee resides in another State, the Department will accept another form of address verification i.e. current utility bill etc. If out of State residents submit other forms of identification the decision to accept it for purposes of being eligible to receive the rural differential rate will be made on a case by case basis.

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.
- Exception may be requested to allow a QSP in a rural area to receive a rural differential rate when providing services in the city limits of Fargo, Bismarck,

Grand Forks, Minot, West Fargo, Mandan, Dickinson, Jamestown, and Williston if the following criteria are met.

- The consumer has at least two ADL impairments and will need at least 100 units of service or supervision needs met to assure health and safety.
- The HCBS case manager has reached out to a minimum of three QSPs in the local area who are unable or unwilling to serve the individual. The HCBS CM must outline the efforts made to find a local QSP. Include the name of the three providers and the date the providers were contacted in the case narrative with a brief description of the reason for the denial.
- QSP cannot be a family member.
- Case Managers must request prior approval from RD Program Administrator.

A request for this exception can be made by sending an email to the program administrator outlining the efforts made to find a local QSP. Include the name of the three providers, the date the providers were contacted, and a brief description of the reason for the denial. The exception email must be kept in the consumer's file and documented in the case narrative.

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.

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

(Revised ~~2/1/17~~ 01/01/2024 ML #~~3489~~ 3795)

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 before level B or Level C is authorized and whenever an individual has not had a 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 prior to authorizing Level B or Level C and 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 prior to authorizing Level B or Level C and 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

Daily

Basic Care

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 Aging Services and the rate will be calculated by Aging 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.

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.

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 Aging 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 is 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 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 month review 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 Aging 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

(Revised ~~2/1/17~~ 01/01/2024 ML #~~3489~~ 3795)

This Section is Repealed.