RULES OF

# Department of Social Services

## Division 70—MO HealthNet Division

## Chapter 91—Personal Care Program

# TITLE 13 — DEPARTMENT OF SOCIAL SERVICES
## Division 70 — MO HealthNet Division
## Chapter 91 — Personal Care Program

### 13 CSR 70-91.010 Personal Care Program

*PURPOSE: Personal care services are medically-oriented services provided in the individual's home, or in a licensed Residential Care Facility I or II to assist with activities of daily living to meet the physical needs of the individual. Personal care services are authorized by a physician in accordance with a plan of care or otherwise authorized in accordance with a service plan approved by the state. This rule establishes the basis for administering the personal care program, including the criteria providers of the service must meet, criteria a recipient of the service must meet, and criteria and method of reimbursement for the services. Specific details of the amount, duration, scope, and limitations of services covered are included in the provider program manuals.*

(1) Persons Eligible for Personal Care Services. Any person who is determined eligible by the Family Support Division for Title XIX benefits and is found to be in medical need of personal care services as an alternative to institutional care. Persons must be assessed, approved, and case-managed by the Department of Health and Senior Services or its designee as described in this rule to be eligible for personal care services. Eligibility procedures for personal care services are as follows:

(A) Requirements for Personal Care Services.

1. The participant must need an institutional level of care which is defined as twenty-four- (24-) hour institutional care on an inpatient or residential basis in a hospital or nursing facility (NF) and approved by the Department of Health and Senior Services or its designee.

2. Level of care will be determined by the Department of Health and Senior Services or its designee.

3. The participant must agree to an in-home assessment performed by the Department of Health and Senior Services or its designee of his/her physical, social, and functional ability to benefit from personal care services;

(B) Obtaining Personal Care Services.

1. If the participant meets all of the eligibility and assessment criteria, the Department of Health and Senior Services or its designee will develop an initial personal care plan to authorize personal care services on a scheduled basis to eligible participants in their own homes, licensed Residential Care Facilities (RCFs) I or II, or Assisted Living Facilities (ALFs) as an alternative to twenty-four- (24-) hour institutional care on an inpatient or residential basis in a hospital or NF. The Department of Health and Senior Services or its designee will forward a copy of the personal care plan to the participant's attending physician and to the personal care provider who will be delivering care. Upon the receipt of the personal care plan, the provider of care must initiate care within ten (10) calendar days of receipt and the physician must register any comments or requests for changes within thirty (30) days of receipt or the personal care plan will stand as written by the Department of Health and Senior Services or its designee.

2. The personal care plan will be developed in collaboration with and signed by the participant. The plan will include an identification of the services and tasks to be provided, frequency of services, and the maximum number of units of service for which the participant is eligible per month.

3. A new in-home assessment and personal care plan may be completed by the Department of Health and Senior Services or its designee as needed to redetermine need for personal care services or to adjust the monthly amount of authorized units. The service provider must always have an active service plan. Only the Department of Health and Senior Services or its designee, not the service provider, may increase the overall maximum number of units for which the individual is eligible per month. Any service plan developed in accordance with paragraphs (1)(B)2. and 3. is a state-approved service plan.

4. The participant will be informed of the option of services available to him/her in accordance with the level-of-care determination and assessment findings; and

(C) Discontinuing Personal Care Services. The following policies and procedures for discontinuing personal care services shall be followed:

1. Services for a participant shall be discontinued by a provider agency under the following circumstances:

A. When the participant's case is closed by the Department of Health and Senior Services or its designee;

B. When the provider learns of circumstances that require the closure of a case for reasons including but not limited to death entry into a nursing home, or the participant no longer needs services. In these circumstances, the provider shall notify the Department of Health and Senior Services or its designee in writing and request that the participant's services be discontinued;

C. When the participant is noncompliant with the agreed-upon plan of care. Noncompliance requires persistent actions by the participant or family which negate the services provided by the agency. After all alternatives have been explored and exhausted, the provider shall notify the Department of Health and Senior Services or its designee in writing of the noncompliant acts and request that the participant's services be discontinued;

D. When the participant or participant's family threatens or abuses the personal care aide or other agency staff to the point where the staff's welfare is in jeopardy and corrective action has failed. The provider shall notify the Department of Health and Senior Services or its designee of the threatening or abusive acts and may request that the service authorization be discontinued;

E. When a provider is unable to continue to meet the maintenance needs of a participant. In these circumstances, the provider shall notify the Department of Health and Senior Services or its designee in writing and request that the participant's services be discontinued; or

F. When a provider is unable to continue to meet the maintenance needs of a participant whose plan of care requires advanced personal care services. In these circumstances the provider shall provide written notice of discharge to the participant or participant's family and the Department of Health and Senior Services or its designee at least twenty-one (21) days prior to the date of discharge. During this twenty-one- (21-) day period, the Department of Health and Senior Services or its designee shall assist in making appropriate arrangements with the participant for transfer to another agency, institutional placement, or other appropriate care. Regardless of circumstances, the personal care provider must continue to provide care in accordance with the plan of care for these twenty-one (21) days or until alternate arrangements can be made by the Department of Health and Senior Services or its designee, whichever comes first; and

2. Discontinuing services for a participant still in need of assistance shall occur only after appropriate conferences with the Department of Health and Senior Services or its designee, participant, and participant's family.

(2) Basic personal care services are medically-oriented, maintenance services to assist with the activities of daily living when this assistance does not require devices and procedures related to altered body functions.

(A) To be eligible for basic personal care, an individual must be in need of personal care services as an alternative to institutional care as specified in section (1) of this rule.

(B) The following activities constitute basic personal care services and shall be provided according to the plan of care:

1. Assistance with dietary needs, including meal preparation and cleanup, and assistance with eating/feeding;

2. Assisting with dressing and grooming, including helping with dressing and undressing, combing hair, and nail care;

3. Assisting with bathing and personal hygiene, including assisting with bathing, shampooing hair, oral hygiene and denture care, and shaving;

4. Assisting with toileting and continence, including assisting in going to the bathroom, and changing bed linen. This category may also include the changing of beds for persons with medically related limitations that prohibit the completion of this task;

5. Assisting with mobility and transfer, including assisting with transfer and ambulation when participants can at least partially bear own weight;

6. Assisting with medication, including assisting with the self-administration of medicine, applying nonprescription topical ointments or lotions; and

7. Medically related household tasks, including approved homemaker and chore tasks.

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

(3) Criteria for Providers of Personal Care Services.

(A) The provider of personal care services must have a valid participation agreement with the Department of Social Services, Missouri Medicaid Audit and Compliance Unit. The issuance of the participation agreement is dependent upon acceptance of an application for enrollment by the Missouri Medicaid Audit and Compliance Unit. The provider must submit to the Missouri Medicaid Audit and Compliance Unit the written proposal required to become a Title XX in-home services provider and be approved to provide Title XX in-home services. Once approved to provide Title XX in-home services by the Missouri Medicaid Audit and Compliance Unit, the provider will be allowed to execute a Title XIX participation agreement with the Missouri Medicaid Audit and Compliance Unit. Thereafter, a provider is not required to actually accept or deliver services to participants who are authorized for both programs or to participants who are authorized for Title XX services only. For residential care facilities that wish to provide services only to the eligible residents of their own facility, only the verification of a state residential care facility license authorized by the Department of Health and Senior Services, Division of Regulation and Licensure, will be required for the Medicaid enrollment application. Providers must maintain their approval to participate as a Title XX provider, whether or not they actually serve Title XX eligible participants, in order to remain qualified to participate in the Title XIX (Medicaid) Personal Care Program.

(B) The providers must agree to comply with any evaluation conducted by the Missouri Medicaid Audit and Compliance Unit. The Missouri Medicaid Audit and Compliance Unit may, in accordance with the protective service mandate (Chapter 192, RSMo), take action to protect participants from providers who are found to be out of compliance with the requirements of its regulations and of any other regulations applicable to the Personal Care Program, when such noncompliance is determined by the Missouri Medicaid Audit and Compliance Unit to create a risk of injury or harm to participants. Evidence of such risk may include unreliable or inadequate provider documentation of services or training due to falsification or fraud, the provider's failure to deliver services in a reliable and dependable manner, or use of personal care aides who do not meet the minimum training standards of this regulation. Immediate action by the Missouri Medicaid Audit and Compliance Unit may include but is not limited to –

1. Removing the provider from any list of providers and, for participants who request the unsafe and noncompliant provider, informing the participants of the determination of noncompliance after which any informed choice will be honored by the Department of Health and Senior Services or its designee; or

2. Informing current participants served by the provider of the provider's noncompliance and that the Division of Senior and Disability Services has determined the provider unable to deliver safe care. Such participants will be allowed to choose a different provider from the list maintained by the Department of Health and Senior Services or its designee, which will then be immediately authorized to provide service to them.

(C) The provider agency must be available to provide care in accordance with the personal care plan, utilizing universal precaution procedures as defined by the Centers for Disease Control and Prevention.

(D) The provider agency must monitor the overall physical care needs of the participant. If the participant's condition warrants, contact the participant's physician and inform the Department of Health and Senior Services or its designee when additional case management activities by the Department of Health and Senior Services or its designee are required.

1. Prior to the delivery of service, the personal care aide shall receive a copy of the care plan for the participant and be provided with information about the participant in order to appropriately deliver services to meet the needs of the participant.

(E) For newly employed aides, the provider agency must, at a minimum, provide twelve (12) hours of orientation training, within thirty (30) days of employment.

1. In calculating these hours, the following requirements shall apply:

A. At least two (2) hours orientation to the provider agency and the agency's protocols for handling emergencies;

B. With a minimum of six (6) hours of training being completed prior to participant contact;

C. Four (4) hours of required orientation may be waived with adequate documentation in the employee's records that the aide received similar training during the previous twelve (12) months, with the exception of the statutorily required dementia training;

D. If an aide is a certified nurse assistant (CNA), licensed practical nurse, or registered nurse, the provider agency may waive all hours of orientation training, with the exception of the two (2) hours' provider agency orientation and the statutorily required dementia training, with adequate documentation placed in the aide's personnel record. The documentation shall include the employee's license or certification number, which must be current and in good standing at the time the training was waived.

2. An additional five (5) hours of in-service training

annually are required after the first twelve (12) months of employment. The provider may waive the required annual five (5) hours of in-service training and require only two (2) hours of refresher training annually when the aide has been employed for three (3) years and has completed fifteen (15) hours of in-service training. In-service training curricula shall include updates on Alzheimer's disease and related dementia.

3. Personal care aides employed by an RCF II or ALF are exempt from the training requirements defined in paragraphs (3)(E)1. and 2. of this rule if they have completed the training requirements described in subdivisions (9) and (10) of subsection 3 of section 198.073, RSMo.

4. The provider agency shall have written documentation of all basic and in-service training provided which includes, at a minimum, a report of each employee's training in that employee's personnel record. The report shall document the dates of all classroom or on-the-job training, trainer's name, topics, number of hours and location, the date of the first participant contact, and shall include the aide's signature. If a provider waives any in-service training, the employee's training record shall contain supportive data for the waiver.

(F) The requirements that have been adopted by the Division of Senior and Disability Services at 19 CSR 15-7.021(18)(A) through (Q) and (18)(T) through (W) shall apply to all providers of personal care services and advanced personal care services.

(G) The provider agency must employ an administrative supervisor of the day-to-day delivery of direct personal care services possessing at least the following qualifications:

1. Be at least twenty-one (21) years of age; and

2. Shall be a registered nurse (RN) who is currently licensed in Missouri; or have at least a baccalaureate degree; or be a licensed practical nurse (LPN) who is currently licensed in Missouri with at least one (1) year of experience with the care of the elderly, or individuals with disabilities or medically complex conditions; or have at least two (2) years' experience with the care of the elderly, or individuals with disabilities or medically complex conditions.

(H) The supervisor's responsibilities shall include, at a minimum, the following:

1. Establish, implement, and enforce a policy governing communicable diseases that prohibits provider staff contact with participants when the employee has a communicable condition, including colds or flu. Assure that reporting requirements governing communicable diseases, including hepatitis and tuberculosis, as set by the Missouri Department of Health and Senior Services (19 CSR 20-20.020), are carried out;

2. Monitor the provision of services by the personal care worker to assure that services are being delivered in accordance with the personal care plan. This shall be primarily in the form of an at least monthly review and comparison of the worker's records of provided services with the personal care plan. The monitoring reports shall be available for review by the Departments of Social Services and Health and Senior Services upon request. Documentation, including the reason, must be kept on authorized services/units not delivered;

3. Make an on-site visit at least annually to evaluate each personal care worker's performance and the adequacy of the service plan, including review of the plan of care with the participant. The personal care worker may or may not be present for this evaluation. A written record of the evaluation shall be maintained in the personnel file of the personal care worker. This record must contain, at a minimum, the participant's name and address, the date and time of the visit, personal care worker's name, observations related to the participant's receipt of care plan delivery, the participant's satisfaction of the personal care worker's performance, and the adequacy of the service plan. In addition, the evaluation shall be signed and dated by the supervisor who prepared it and by the personal care worker. If the required evaluation is not performed or not documented, the personal care worker's qualifications to provide the services may be presumed inadequate and all payments made for services by that personal care worker may be recouped;

4. Approve, in advance, all changes to the plan of care based on supervisory on-site visits, information from the personal care worker, or observation by the RN, or a combination of these. Approval of changes shall be noted and dated in the participant's file;

5. Make appropriate recommendations to the Department of Health and Senior Services or its designee including proposed increase, reduction, or termination of services; or need for increased Department of Health and Senior Services involvement based on supervisory on-site visits, review of reports, information from the personal care worker, observation by the RN; or a combination of these;

6. Be available for regular case conferences with the Department of Health and Senior Services or its designee; and

7. Assist in orientation and personal care training for personal care workers.

(I) If the supervisor is not an RN, the provider agency must have a designated RN currently licensed in Missouri either on staff or employed as a consultant.

(J) The RN's responsibilities shall include to initial and review all on-site visit reports made by the administrative supervisor. If supervised by an RN, an LPN or Graduate Nurse (GN) may perform the RN supervisory activities described in this section.

(K) An in-home personal care worker(s) shall meet the following requirements:

1. Be at least eighteen (18) years of age;

2. Be able to read, write, and follow directions; and

3. May not be a family member of the participant for whom personal care is to be provided. A family member is defined as a spouse; parent; sibling; child by blood, adoption, or marriage (step-child); grandparent; or grandchild.

(4) Reimbursement.

(A) Payment will be made in accordance with the fee per unit of service as defined and determined by the MO HealthNet Division.

1. A unit of service is fifteen (15) minutes.

2. Documentation for services delivered by the provider must include the following:

A. The participant's name and Medicaid number;

B. The date of service;

C. The time spent providing the service which must be documented in one (1) of the following manners:

(I) When a personal care aide is providing services to one (1) individual in a private home setting and devotes undivided attention to the care required by that individual, the actual clock time the aide began the services for that visit shall be documented as the start time, and the actual clock time the aide finished the care for the visit shall be documented as the stop time per Electronic Visit Verification (EVV) regulation 13 CSR 70-3.320; and

(II) When the personal care services are provided in a congregate living setting, such as RCFs I and II or ALFs, when on-site supervision is available and personal care aide staff will divide their time among a number of individuals, the following must be documented: all tasks performed for each participant by date of service and by staff shifts during each

twenty-four- (24-) hour period;

D. A description of the service; and

E. The name of the personal care aide who provided the service.

3. A provider may not bill time spent in the delivery of service of less than one (1) unit of service for any participant. However, time spent in the delivery of service of less than one (1) full unit for any participant may be accrued by the provider to establish a unit of service. In no event may time spent in the delivery of service be accrued beyond the last day of the calendar month in which such services were rendered.

4. The fee per unit of service will be based on the determination by the state agency of the reasonable cost of providing the covered services on a statewide basis and within the mandatory maximum payment limitations.

(B) Conditions for Reimbursement.

1. The personal care plan will be the authorization for payment of service.

2. The total monthly payment for basic personal care services made on behalf of an individual who requires basic personal care only cannot exceed sixty percent (60%) of the average statewide monthly cost for care in a nursing facility as defined in 13 CSR 70-10.010(4)(Q) (excluding intermediate care facilities for individuals with intellectual disabilities (ICFs/IID)).

3. The average monthly cost to the state for care in an NF as defined in 13 CSR 70-10.010(4)(Q) (excluding ICFs/IID) will be established in the month of May of each state fiscal year which will become effective on July 1 of the following state fiscal year.

4. Payment will be made on the lower of the established rate per service unit or the provider's billed charges.

5. Rates will be established for personal care services in private homes, licensed RCFs I and II, and ALFs.

(5) Advanced personal care services are maintenance services provided to a participant in the participant's home to assist with activities of daily living when this assistance requires devices and procedures related to altered body functions.

(A) Persons Eligible for Advanced Personal Care Services. Any person who is determined eligible for Title XIX benefits from the Family Support Division, found to be in need of personal care services as an alternative to institutional care as specified in section (1) of this rule, and who requires devices and procedures related to altered body functions is eligible for advanced personal care services.

(B) The following activities constitute advanced personal care services and shall be provided according to the plan of care:

1. Routine personal care of persons with ostomies (including tracheostomies, gastrostomies, colostomies all with well-healed stoma), which includes changing bags and soap and water hygiene around ostomy site;

2. Personal care of persons with external, indwelling, and suprapubic catheters, which include changing bags and soap and water hygiene around site;

3. Removal of external catheters, inspect skin and reapply catheter;

4. Administration of prescribed bowel programs, including use of suppositories and sphincter stimulation per protocol and enemas (prepacked only) without contraindicating rectal or intestinal conditions;

5. Application of medicated (prescription) lotions, ointments or dry, aseptic dressings to unbroken skin including stage I *decubitus*;

6. Application of aseptic dressings to superficial skin breaks or abrasions as directed by a licensed nurse;

7. Manual assistance with noninjectable medications as set up by a licensed nurse;

8. Passive range of motion (nonresistive flexion of joint within normal range) delivered in accordance with the care plan; and

9. Use of assistive device for transfers.

(C) Instruction and encouragement to the participant in ways to become more self-sufficient in advanced personal care may be a component of all tasks as described above; however, instruction and encouragement in and of themselves do not constitute a task.

(D) Advanced Personal Care Plans. Plans of care which include advanced personal care services must be developed by the provider agency RN in collaboration with state agency staff or its designee.

(E) Criteria for Providers of Advanced Personal Care Services. Providers of advanced personal care must meet all criteria for providers of personal care services described in section (3) of this rule. Providers must sign an addendum to their Title XIX Personal Care Provider Agreement and must possess a valid contract with the Missouri Medicaid Audit and Compliance Unit to provide Title XX services including advanced personal care services. Residential care facilities wishing to provide advanced personal care services to the eligible residents of their own facility only may do so with a signed addendum to their Title XIX Personal Care Provider Agreement.

1. All advanced personal care aides employed by the provider must be an LPN or a certified nurse assistant, or a competency-evaluated home health aide having completed both written and demonstration portions of the test required by the Missouri Department of Health and Senior Services and 42 CFR 484.80, or have successfully completed personal care aide training. In addition, advanced personal care aides may not be related to the participant to whom they provide personal care, as defined in paragraph (3)(K)3. of this rule.

2. Personal care providers are required to provide training to advanced personal care aides, in addition to the orientation training described in section (3) of this rule. The additional training shall consist of a minimum of six (6) hours and must be completed prior to the provision of any advanced personal care tasks. Providers may waive this six (6) hours of training if one (1) of the following are met:

A. The proposed advanced personal care (APC) aide is an LPN or CNA currently licensed or registered in the state of Missouri; or

B. The proposed advanced personal care aide has previously completed advanced personal care training from a Medicaid or Social Services Block Grant (SSBG) in-home provider agency, and that same personal care aide has been employed by a Medicaid or SSBG in-home provider agency as an advanced personal care aide within the prior six (6) months.

3. Advanced personal care aides employed by an RCF II are exempt from the training requirements defined in paragraphs (5)(E)1. and 2. of this rule if they have completed the training requirements described in subdivisions (9) and (10) of subsection 3 of section 198.073, RSMo, as amended.

4. The additional advanced personal care training must include, at a minimum, the following topics:

A. Observation of the participant and reporting observation;

B. Application of ointments/lotions to unbroken skin;

C. Manual assistance with oral medications;

D. Prevention of *decubiti*;

E. Bowel routines (rectal suppositories, sphincter stimulation);

F. Enemas;

G. Personal care for persons with ostomies and catheters;

H. Proper cleaning of catheter bags;

I. Positioning and support of the participant;

J. Range of motion exercises;

K. Application of nonsterile dressings to superficial skin breaks; and

L. Universal precaution procedures as defined by the Centers for Disease Control and Prevention.

5. Advanced personal care tasks as specified at (5)(B)1. through 9. shall not be assigned to or performed by any advanced personal care aide who is not a licensed nurse until the aide has been fully trained to perform the task, the RN, LPN, or GN has personally observed successful execution of the task and the RN, LPN, or GN has personally certified this in the aide's personnel record. An LPN or GN observing the execution of a task must be trained in the APC tasks and observed by the RN supervisor for successful completion of each task, and the RN supervisor must personally certify this in the LPN's or GN's personnel record. Only RN visits necessary for task observation and certification in the home may be prior authorized and billed to MO HealthNet Division as an authorized nurse visit, as described in section (6) of this rule. RN task observation and certification in a laboratory, or other non-home setting, may not be billed.

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

7. For participants receiving advanced personal care services, it is required that on-site RN visits be conducted at intervals of no greater than six (6) months. During these visits, the RN must conduct and document an evaluation of the participant's condition, continued eligibility for the program, and the adequacy of the care plan. The RN must sign the evaluation and the provider shall maintain documentation of the evaluation in the participant's record. The evaluation must be produced upon request of the Division of Senior and Disability Services or the Missouri Medicaid Audit and Compliance Unit.

(F) Reimbursement.

1. Payment for advanced personal care services will be made in accordance with the fee per unit of service as defined and determined by the MO HealthNet Division. The fee per unit (fifteen (15) minutes) of service will be based on the determination of the state agency of the reasonable cost of providing the covered services on a statewide basis and within the mandatory maximum payment limitations.

2. Conditions for reimbursement.

A. An advanced personal care plan is required. It is to be developed by the Department of Health and Senior Services or its designee in cooperation with the provider agency's RN. The provider agency is responsible for obtaining the participant's physician's approval for the plan.

B. The total monthly payment for advanced personal care services as described in this section and for personal care services as described in sections (1)–(7) of this rule made on behalf of an individual cannot exceed one hundred percent (100%) of the average statewide monthly cost for care in an NF as defined in 13 CSR 70-10.010(4)(Q) (excluding ICFs/IID).

C. The average monthly cost to the state for care in an NF, as defined in 13 CSR 70-10.010(4)(Q) (excluding ICF/IID), will be established in the month of May of each state fiscal year, which will become effective on July 1 of the following state fiscal year.

D. Payment will be made on the lower of the established rate per service unit or the provider's billed charges.

3. Rates will be established for personal care services in private homes, licensed RCFs I and II, and ALFs.

(6) Separately Authorized Nurses Visits.

(A) The provisions of paragraph (3)(H)3. notwithstanding, reimbursement will be made for visits by nurse to particular participants with special needs when the visits are prior authorized by the Department of Health and Senior Services or its designee. Providers of personal care services must have the capacity to provide these authorized nurse visits in addition to the nonauthorized nurse visits required by subsection (3)(J). Anytime an authorized nurse visit is made, the nurse shall also, in addition to other duties, evaluate the adequacy of the plan of care, including a review of the plan of care with the participant.

(B) To be eligible to receive the authorized nurse visit, the participant must –

1. Be determined eligible for Title XIX benefits from the Family Support Division and found to be in need of personal care services as an alternative to institutional care as specified in section (1) of this rule;

2. Have no other person available who could and would provide the services;

3. Require one (1) or more of the services described in subsection (6)(D) as an alternative to institutionalized care; and

4. Meet any additional criteria of need set forth in subsection (6)(D).

(C) The services provided during the authorized nurse visit shall not include any service which the participant would be eligible to receive under either the Medicare (Title XVIII) or Medicaid (Title XIX) Home Health programs. The services listed in subsection (6)(D) do not qualify, by themselves, for reimbursement under either program. However, should a participant otherwise be eligible for home health services, then those services listed in paragraphs (6)(D)1.–4. will be provided by the home health agency and not under the Personal Care Program.

(D) The services of the nurse shall provide increased supervision of the aide, assessment of the participant's health, and the suitability of the care plan to meet the participant's needs. These services also shall include any referral or follow-up action indicated by the nurse's assessment. These services, in addition, must include one (1) or more of the following where appropriate to the needs of the participant and authorized by the Department of Health and Senior Services or its designee:

1. The RN may fill insulin syringes in advance per manufacturer's instructions for participants with diabetes who can self-inject the medication but cannot fill their own syringe. This service would include monitoring the participant's continued ability to self-administer the insulin;

2. The RN may set up oral medications in divided daily compartments for a participant who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

3. The RN may monitor a participant's skin condition when a participant is at risk of skin breakdown due to immobility, incontinency, or both;

4. The RN may provide nail care for a participant with diabetes or other medically contraindicating conditions if the participant is unable to perform this task;

5. The RN will be authorized to visit all personal care participants who also receive advanced personal care as

described in section (4) of this rule, on a monthly basis, to evaluate the adequacy of the authorized services to meet the needs and conditions of the participant and to assess the advanced personal care aide's ability to carry out the authorized services;

6. The RN may provide on-the-job training to advanced personal care aides as described in paragraph (5)(E)6. of this rule;

7. The visits authorized under section (6) may be carried out by an LPN or GN, if under the direction of an RN; or

8. The RN may be authorized to provide other services in other situations, subject to the conditions set forth in subsection (6)(C).

(E) Payment for the authorized nurse visit will be made in accordance with the fee per unit of service as defined and determined by the MO HealthNet Division.

1. A unit of service is the visit. No minimum or maximum time is required to constitute a visit.

2. The maximum number of units which a participant can receive is twenty-six (26) within a six- (6-) month period of time. The cost of the nurse visits are not included in the spending cap set forth in paragraph (4)(B)2. but must be included in the spending cap specified at subparagraph (5)(F)2.B.

(F) Documentation of the authorized nurse visit shall include written notes and observations. These will be maintained in the participant's file. In addition, notes of any verbal communication and copies of any written communications with the participant's physician or other health care professional concerning the care of that participant also will be maintained in the participant's file.

*AUTHORITY: section 208.152, RSMo Supp. 2022, and sections 208.153 and 208.159, RSMo 2016.* This rule was previously filed as 13 CSR 40-81.125. Original rule filed April 14, 1982, effective July 11, 1982. Amended: Filed May 13, 1983, effective Aug. 11, 1983. Amended: Filed May 11, 1984, effective Aug. 11, 1984. Emergency amendment filed June 25, 1986, effective July 5, 1986, expired Nov. 2, 1986. Amended: Filed July 25, 1986, effective Oct. 11, 1986. Emergency amendment filed Sept. 1, 1989, effective Sept. 11, 1989, expired Jan. 7, 1990. Amended: Filed Oct. 3, 1989, effective Dec. 28, 1989. Emergency amendment filed July 31, 1992, effective Aug. 10, 1992, expired Dec. 7, 1992. Emergency amendment filed Nov. 25, 1992, effective Dec. 8, 1992, expired April 6, 1993. Amended: Filed July 31, 1992, effective April 8, 1993. Emergency amendment filed June 18, 1993, effective July 1, 1993, expired Oct. 28, 1993. Emergency amendment filed Sept. 2, 1993, effective Oct. 1, 1993, expired Jan. 28, 1994. Emergency amendment filed Feb. 2, 1994, effective Feb. 12, 1994, expired June 11, 1994. Amended: Filed Sept. 2, 1993, effective April 9, 1994. Emergency amendment filed April 4, 1994, effective May 1, 1994, expired Aug. 28, 1994. Amended: Filed April 4, 1994, effective Oct. 30, 1994. Emergency amendment filed Oct. 14, 1994, effective Oct. 24, 1995, expired Feb. 20, 1995. Emergency amendment filed March 31, 1995, effective April 13, 1995, expired Aug. 10, 1995. Amended: Filed Oct. 21, 1994, effective June 30, 1995. Amended: Filed Aug. 1, 1996, effective March 30, 1997. Amended: Filed Aug. 29, 1997, effective April 30, 1998. Amended: Filed Dec. 15, 1997, effective July 30, 1998. Amended: Filed Dec. 15, 2000, effective June 30, 2001. Amended: Filed Jan. 15, 2004, effective Aug. 30, 2004. Amended: Filed April 29, 2005, effective Oct. 30, 2005. ** Amended: Filed Feb. 6, 2023, effective Aug. 30, 2023.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018, 2021; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; and 208.159, RSMo 1979.*

***Pursuant to Executive Order 21-07, 13 CSR 70-91.010, paragraph (1)(B)3. and subparagraph (1)(C)1.F. was suspended from April 30, 2020 through May 1, 2021. Pursuant to Executive Order 21-09, 13 CSR 70-91.010, paragraph (1)(B)1., subsections (3)(E) and (3)(G), paragraphs (3)(H)2., (3)(H)3., (3)(J)1., (3)(K)3., and (3)(K)4., subparagraph (4)(A)2.F., paragraphs (4)(B)1.-2., subparagraphs (5)(F)2.A.-B., and subsection (5)(E) was suspended from April 30, 2020 through December 31, 2021.*

**13 CSR 70-91.020 Mental Health Residential Personal Care Program**

(Rescinded June 30, 2018)

*AUTHORITY: sections 208.152, RSMo Supp. 1993, 208.153, RSMo Supp. 1991 and 208.201, RSMo 1987. Emergency rule filed March 18, 1993, effective April 1, 1993, expired July 29, 1993. Emergency rule filed July 6, 1993, effective July 30, 1993, expired Nov. 26, 1993. Original rule filed March 16, 1993, effective Oct. 10, 1993. Rescinded: Filed Nov. 3, 2017, effective June 30, 2018.*

**13 CSR 70-91.030 Personal Care Assistance**

(Rescinded December 30, 2010)

*AUTHORITY: sections 208.153 and 208.201, RSMo 2000. Emergency rule filed Oct. 3, 1994, effective Nov. 1, 1994, expired Jan. 29, 1995. Original rule filed Oct. 28, 1994, effective June 30, 1995. Amended: Filed March 2, 1998, effective Sept. 30, 1998. Amended: Filed Jan. 15, 2004, effective Aug. 30, 2004. Rescinded: Filed June 10, 2010, effective Dec. 30, 2010.*