Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 91—Personal Care Program

Title 13—DEPARTMENT OF SOCIAL SERVICES
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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.

PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

(1) Persons Eligible for Personal Care Services. Any person who is determined eligible by the Division of Family Services 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 Division of Aging as described in this rule, to be eligible for personal care services. Eligibility procedures for personal care services are as follows:

(A) Recommendations for Personal Care Services.

1. The recipient 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 Division of Aging.

2. Level of care will be determined by Division of Aging.

3. The recipient must agree to an in-home assessment as performed by Division of Aging staff of his/her physical, social and functional ability to benefit from personal care services;

(B) Obtaining Personal Care Services.

1. If the recipient meets all of the eligibility and assessment criteria, the Division of Aging staff will develop an initial personal care plan to authorize personal care services on a scheduled basis to eligible recipients in their own homes or licensed Residential Care Facility I or II as an alternative to twenty-four (24)-hour institutional care on an inpatient or residential basis in a hospital or NF. The Division of Aging will forward a copy of the personal care plan to the client'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 seven (7) 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 Division of Aging.

2. The personal care plan will be developed in collaboration with and signed by the recipient. The plan will include a list of tasks to be performed, weekly schedule of service delivery, and the maximum number of units of service for which the recipient is eligible per month.

3. A new in-home assessment and personal care plan may be completed by the Division of Aging as needed to redetermine need for personal care services or to adjust the monthly amount of authorized units. In collaboration with the service recipient, the service agency may develop a new or revised set of personal care tasks, and weekly schedule of service delivery which shall be forwarded to the Division of Aging. The service provider must always have, and provide services in accordance with, a current service plan. Only the Division of Aging, not the service provider, may increase the 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 recipient 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 client shall be discontinued by a provider agency under the following circumstances:

A. When the client's case is closed by the state agency;

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 client no longer needs services. In these circumstances, the provider shall notify the state agency case manager in writing and request that the client's services be discontinued;

C. When the client is noncompliant with the agreed upon plan of care. Noncompliance requires persistent actions by the client or family which negate the services provided by the agency. After all alternatives have been explored and exhausted, the provider shall notify the state agency case manager in writing of the noncompliant acts and request that the client's services be discontinued;

D. When the client or client'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 state agency case manager 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 client. In these circumstances, the provider shall notify the state agency case manager in writing and request that the client's services be discontinued; or

F. When a provider is unable to continue to meet the maintenance needs of a client whose plan of care requires advanced personal care services. In these circumstances the provider shall provide written notice of discharge to the client or client's family and the state agency case manager at least twenty-one (21) days prior to the date of discharge. During this twenty-one (21)-day period, the state agency case manager shall assist in making appropriate arrangements with the client 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 case manager, whichever comes first; and

2. Discontinuing services for a client still in need of assistance shall occur only after appropriate conferences with the state agency case manager, client and client'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 recipient 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 recipients 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 state Medicaid agency. The issuance of the participation agreement is dependent upon the Department of Social Services' acceptance of an application for enrollment. The provider must submit to the Department of Social Services, Division of Aging, 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 Division of Aging, the provider will be allowed to execute a Title XIX participation agreement with the Division of Medical Services. Thereafter, a provider is not required to actually accept or deliver services to clients who are authorized for both programs or to clients 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 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 clients, 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 Department of Social Services. In circumstances in which the Division of Aging has taken action to protect clients 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 Division of Aging to create a risk of injury or harm to clients. 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 Division of Aging may include, but is not limited to:

1. Removing the provider from any list of providers, and for clients who request the unsafe and noncompliant provider, informing the clients of the determination of noncompliance after which any informed choice will be honored by the Division of Aging; or

2. Informing current clients served by the provider of the provider's noncompliance and that the Division of Aging has determined the provider unable to deliver safe care. Such clients will be allowed to choose a different provider from the list maintained by the Division of Aging 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 Center for Disease Control.

(D) The provider agency must monitor the overall physical care needs of the service recipient. If the client's condition warrants, contact the client's physician and inform the Division of Aging when additional Division of Aging case management activities are required.

(E) For newly employed aides, the provider agency must, at a minimum, provide twenty (20) hours of orientation training.

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, within thirty (30) days of employment;

B. With eight (8) hours of classroom training being completed prior to client contact;

C. Twelve (12) hours of orientation may be waived with adequate documentation in the employee's records that the aide received similar training during the current or preceding state fiscal year or has been employed as an aide at an in-home or home health agency at least half-time for six (6) months or more within the current or preceding state fiscal year;

D. If an aide is a certified nurse assistant, licensed practical nurse, or registered nurse, the provider agency may waive all orientation training, except the two (2) hours' provider agency orientation, with documentation placed in the aide's personnel record. The documentation shall include the employee's license or certification number current at the time the training was waived.

2. An additional ten (10) hours of in-service training annually are required after the first twelve (12) months of employment.

3. Personal care aides employed by an RCF II 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 Supp. 1999.

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 client 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 Aging at 13 CSR 15-7.021(18)(A) through (R) and (18)(U) 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 direct care of the elderly, disabled or infirm; or have at least three (3) years' experience with the care of the elderly, disabled or infirm.

(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 clients 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 (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 Department of Social Services upon request. Documentation must be kept on clients with a delivery rate of less than eighty percent (80%) of the authorized units of in-home service. For each client with a delivery rate less than eighty percent (80%) of the number of units of in-home services authorized for the time period being reviewed, the number of units of service delivered and nondelivered code will be sent to the Division of Aging regional manager monthly. Discrepancies for these clients concerning the frequency of delivered services and/or the in-home service tasks delivered, the corrective action taken, will be signed and dated by the supervisor and be readily available for monitoring or inspection;

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 recipient. The personal care worker must 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 service recipient's name and address; the date and time of the visit, personal care worker's name and observations of both 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. Unless, medically, the recipient's condition supports a visit or all recipients have been visited, a service recipient shall not receive more than one (1) combined on-site supervisory visit and RN on-site visit as specified in paragraph (3)(J)1. per state fiscal year;

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 service recipient's file;

5. Make appropriate recommendations to the Division of Aging worker including increase, reduction or termination of services; or need for increased Division of Aging case management 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 Division of Aging case manager; 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, at a minimum, the following:

1. Monthly on-site visits of basic personal care recipients based on a ten percent (10%) sample of the provider agencies' combined Title XIX and Title XX caseload size as of the beginning of each month. This ten percent (10%) sample is to exclude personal care and advanced personal care recipients receiving authorized nurse visits and on-site supervisory visits, as specified in paragraph (3)(H)3., unless all clients have already been seen or the recipient condition supports a visit. A maximum of thirty (30) visits will be required for those agencies that service over three hundred (300) recipients on a monthly basis with a minimum of two (2) visits monthly for agencies servicing fewer than twenty (20) clients monthly. The home visit shall consist of an evaluation of the adequacy of the plan of care in meeting the needs and condition of the recipient, and shall include a review of the plan of care with the recipient, and assessment of the personal care worker relative to his/her ability to carry out the plan of care. The RN must maintain an on-site visiting log. The log must contain, at a minimum, the service recipient's name, address, the date of the visit, the personal care worker's name and observations of both the personal care worker's performance and the adequacy of the service plan. Unless supported by the recipient's medical condition or all recipients have been visited, a service recipient shall not receive more than one (1) combined RN on-site visit and supervisory on-site visit as specified in paragraph (3)(H)3. per state fiscal year;

2. Initial and review all on-site visit reports made by the personal care supervisor; and

3. If supervised by an RN, an LPN 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;

3. Have at least six (6) months' paid work experience as an agency homemaker, nurse aide or household worker, or at least one (1) year of experience, paid or unpaid, in caring for children, sick or aged individuals, or have successfully completed formal training, such as the basic nursing arts course of nurse's training, nursing assistant training or home health-aid training; and

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

(4) Reimbursement.

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

1. A unit of service is one (1) hour.

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

A. The recipient's name and Medicaid number;

B. The date of service;

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

(I) When 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 is the start time, and the actual clock time the aide finished the care for the visit is the stop time; and

(II) When the personal care services are provided in a congregate living setting, such as a Residential Care Facility I and II, 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 recipient by date of services and by staff shifts during each twenty-four (24)-hour period;

D. A description of the service;

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

F. For each date of service: the signature of the recipient, or the mark of the recipient witnessed by at least one (1) person, or the signature of another responsible person present in the recipient's home or licensed Residential Care Facility I or II at the time of service. "Responsible person" may include the personal care aide's supervisor, if the supervisor is present in the home at the time of service delivery. The personal care aide may only sign on behalf of the recipient when the recipient is unable to sign and there is no other responsible person present.

3. A provider may not bill time spent in the delivery of service of less than one (1) unit of service for any recipient. However, time spent in the delivery of service of less than one (1) full hour for any recipient 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 in 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 the mentally retarded (ICFs/MR)).

3. The average monthly cost to the state for care in NF as defined in 13 CSR 70-10.010(4)(Q) (excluding ICFs/MR) 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 and in licensed Residential Care Facilities I and II.

(5) Advanced personal care services are maintenance services provided to a recipient in the individual'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 Division of Family Services, 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 includes 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) with clients 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 client in ways to become more self-sufficient in advanced personal care may be a component of all tasks as described above, in and of themselves and 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.

(E) Criteria for Provider 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 Department of Social Services, Division of Aging 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 only 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 42 CFR 484.36; or have successfully worked for the provider for a minimum of three (3) consecutive months while working at least fifteen (15) hours per week as an in-home aide that has received personal care training. In addition, advanced personal care aides may not be related to the recipient to whom they provide personal care, as defined in paragraph (3)(K)4. of this rule.

2. Personal care providers are required to provide training to advanced personal care aides, in addition to the preservice training requirements described in section (3) of this rule. The additional training shall consist of eight (8) classroom hours and must be completed prior to the provision of any advanced personal care tasks. Providers may waive this eight (8) hours of training if the proposed advanced personal care (APC) aide is an LPN or certified nurse assistant (CNA) currently licensed or registered in the state of Missouri.

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 Supp. 1999.

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

A. Observation of the client 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 client;

J. Range of motion exercises;

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

L. Universal precaution procedures as defined by the Center for Disease Control.

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 supervisor has personally observed successful execution of the task and the RN supervisor has personally certified this in the aide's personnel record. Only RN visits necessary for task observation and certification in the home may be prior authorized and billed to Medicaid 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 supervisor may observe the execution of any of the tasks in a recipient's home. However, tasks specified in paragraphs (5)(B)1., 2., 3., 4., and 9. must be observed in the home, while those specified in paragraphs (5)(B)5., 6., 7., and 8. may be observed in either a home or lab setting.

7. For clients 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 contemporaneously record and certify by his/her signature an individualized valuation of the client's condition and the adequacy of the service plan.

(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 Division of Medical Services. The fee per unit (hour) 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 state agency staff in cooperation with the provider agency's RN. The provider agency is responsible for obtaining the recipient'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 in 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/MR).

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/MR), 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 and in licensed Residential Care Facilities I and II.

(6) Separately Authorized Nurses Visits.

(A) The provisions of paragraphs (3)(J)1.and (3)(H)3. notwithstanding, reimbursement will be made for visits by a nurse to particular clients with special needs, when the visits are prior authorized by the Division of Aging. 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); however, any client who receives an authorized nurse visit in one (1) month shall not be included in the population from which the ten percent (10%) sample for that month's supervisory visits is drawn in accordance with paragraph (3)(J)1. 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 recipient.

(B) To be eligible to receive the authorized nurse visit, the recipient must—

1. Be determined eligible for Title XIX benefits from the Division of Family Services 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 client 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 client 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 client's health and the suitability of the care plan to meet the client'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 client and authorized by the Division of Aging:

1. The RN may fill a one (1)-week supply of insulin syringes for diabetics who can self-inject the medication but cannot fill their own syringe. This service would include monitoring the patient's continued ability to self-administer the insulin;

2. The RN may set up oral medications in divided daily compartments for a client 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 recipient's skin condition when a client is at risk of skin breakdown due to immobility, incontinency, or both;

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

5. The RN will be authorized to visit all personal care recipients 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 client, 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 (4)(C)4. of this rule;

7. The visits authorized under section (6) except (6)(D)6. may be carried out by an LPN, 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 Division of Medical Services.

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 client 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 recipient's file. In addition, notes of any verbal communication and copies of any written communications with the recipient's physician or other health care professional concerning the care of that recipient also will be maintained in the recipient's file.

(7) In accordance with the specific provisions of this rule for assessment, determination and management of level-of-care need and the delivery of personal care services and, as limited to and in accordance with, the terms of an interagency agreement between the Missouri Department of Health and the Missouri Department of Social Services, Division of Medical Services under which personal care services are provided on and after July 1, 1989, as a state plan service to certain recipient victims of acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC) and human immunodeficiency virus (HIV)-related illnesses, the role and function of the Division of Aging shall be assumed by the Department of Health and its contract service coordination staff.

AUTHORITY: sections 208.152, 208.153 and 208.201, RSMo 2000. 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.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993; 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991; and 208.201, RSMo 1987.*

13 CSR 70-91.020 Mental Health Residential Personal Care Program

PURPOSE: This rule establishes the basis for administering a personal care program for residents of community residential facilities licensed by the Department of Mental Health.

(1) Mental Health Residential Personal Care services are medically oriented activities which assist a resident of a community residential facility licensed by the Department of Mental Health (DMH) with activities of daily living and which serve to maintain the resident's highest physical and mental functional state in the least restrictive environment.

(A) A person eligible for Mental Health Residential Personal Care services includes any person who is determined eligible for Title XIX benefits from the Division of Family Services, assessed to be in need of personal care services as an alternative to institutional care, requires specialized personal care and procedures related to diminished mental or physical capacity and is a resident of an eligible provider facility. The recipient's need for an institutional level of care shall be redetermined annually by staff and agents of the DMH, who shall also conduct an annual assessment of each recipient's need for personal care assistance and, from the assessment, develop a plan of care.

(B) Mental Health Residential Personal Care services for each individual shall be specified in a plan of care approved by a physician and developed in conjunction with an individualized habilitation plan (IHP) or individualized treatment plan (ITP) developed by the DMH or its administrative agent. All personal care plans developed by the IHP and ITP teams may extend for one (1) year. Mental health residential personal care services include the following:

1. Basic service tasks include:

A. Preparation of special diet;

B. Assistance or direction with feeding/eating;

C. Assistance or direction with dressing/undressing;

D. Assistance or direction with hair care or grooming, or both;

E. Assistance or direction with brushing teeth and cleaning dentures;

F. Assistance or direction with shaving;

G. Assistance or direction with nailcare for individuals without contraindicating conditions;

H. Assistance or direction with bathing, showering or bed baths;

I. Assistance or direction with menstrual care;

J. Assistance or direction with applying nonprescription topical ointments/lotions to unbroken skin;

K. Assistance or direction with toileting, including assisting with a bedpan;

L. Assistance or direction with walking or using a wheelchair or walker;

M. Assistance or direction with ordinarily self-administered medication and manual assistance with oral medications in accordance with the provider facility's license;

N. Assistance with passive range of motion (nonresistive flexion of joint) in accordance with the plan of care, unless contraindicated by underlying joint pathology;

O. Assistance or direction with maintenance exercise programs post-surgery;

P. Assistance or direction with transfers, with or without lift;

Q. Assistance or direction with using adaptive equipment;

R. The making of beds/changing of sheets with resident in or out of the bed;

S. Turning and positioning;

T. Individual instruction to become self-sufficient in personal care;

U. Nonroutine, medically necessary housework such as laundry and cleaning of the individual's personal living space (bedroom and bath) required due to the individual's inability to manage bodily functions, need for infection control, for example; or

V. Performance of essential errands required for the health and maintenance of

the individual, such as shopping for special nutritional supplements and picking up medications;

2. Advanced service tasks include:

A. Perform routine personal care for persons with ostomies (including tracheostomies, gastrostomies and colostomies with well-healed stoma) and external, indwelling and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;

B. Remove external catheters, inspect skin and reapply same;

C. Administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (prepackaged only) with clients without contraindicating rectal or intestinal conditions;

D. Apply medicated (prescription) lotions or ointments, and dry, nonsterile dressings to unbroken skin;

E. Apply nonsterile dressing to superficial skin breaks or abrasions as directed by a registered nurse or licensed practical nurse; or

F. Use universal precautions as defined by the Center for Disease Control;

3. Registered nurse supervision required for the provision of advanced services. A registered nurse shall—

A. Assist the habilitation/treatment staff with the initial assessment and development of any initial plan of care containing advanced service tasks;

B. Evaluate the condition of the individual at least monthly, except that this evaluation may be conducted by a licensed practical nurse under the registered nurse's supervision. However, the registered nurse him/herself must evaluate the adequacy of the authorized services for each advanced personal care recipient at six (6)-month intervals; and

C. Train and certify an aide's proficiency in each advanced personal care task prior to the aide performing it on/for a recipient.

(2) Criteria for Providers of Mental Health Residential Personal Care Services.

(A) Providers of Mental Health Residential Personal Care Services shall be regional centers or administrative agents of the DMH or facilities licensed by the DMH under 9 CSR 40-1, 9 CSR 40-2 and one (1) of the following: 9 CSR 40-4; 9 CSR 40-5; 9 CSR 40-6; 9 CSR 40-7; 9 CSR 40-8; 9 CSR 40-11; or 9 CSR 40-12. Providers other than regional centers or administrative agents of the DMH also shall have a community placement agreement or its equivalent in effect with the DMH.

(B) Providers shall conduct or arrange training programs as required for licensure by the DMH and these programs shall include training in techniques and documentation of basic service tasks. In addition, a facility which accepts individuals in need of advanced service tasks, as defined in paragraph (1)(B)2. of this rule, shall provide or arrange for additional training related to those functions and shall employ, contract with or arrange for a registered nurse to assure that staff who perform advanced service tasks are trained and competent to perform them. All non-registered nurse or licensed practical nurse staff administering medication shall successfully complete a course on medication approved by the DMH as required for licensure.

(3) Required nurse supervision of Mental Health Residential Personal Care basic services shall consist of at least an annual on-site supervisory review for each client, performed by a registered nurse or by a licensed practical nurse under the registered nurses supervision. Any client for whom advanced service tasks are performed shall be evaluated monthly by either a registered nurse or a nurse under the registered nurses supervision, except that the evaluation must be performed by the registered nurse at least once every six (6) months. Any provider not otherwise required by licensure or DMH community placement contract, or both, to have a registered nurse on staff or under contract may arrange with another enrolled provider, including facilities and agents of the DMH, to provide the required nurse supervision.

(4) Reimbursement for Mental Health Residential Personal Care services shall exceed neither one hundred percent (100%) of the average cost for care in a nursing facility for the same period of time, as determined by the Division of Medical Services, nor the provider's usual and customary rate for personal care services as charged to the DMH. Payment shall be made at the lower of the provider's billed charge or the maximum allowable fee per unit as determined by the Division of Medical Services. The maximum allowable fee per unit shall be an amount per day determined by the Division of Medical Services by dividing the average statewide monthly cost for care in a nursing facility, excluding intermediate care facilities for the mentally retarded, by the average number of days in a month. The provider's billed charge for each recipient shall be determined as follows:

(A) For each recipient the assessed monthly hours of basic and advanced levels of service required for that individual, plus any nurse visits which the facility will be required to provide for advanced tasks, times the fees per hour or per visit of service for each level and type of service as defined and determined by the Division of Medical Services, shall be summed by the DMH and compared to the average statewide monthly cost for care in a nursing facility determined by the Division of Medical Services and to the facility's usual and customary monthly rate for personal care services as charged to the DMH. The lowest of these three (3) figures shall be the direct service cost for that recipient;

(B) If no authorized registered nurse visits are needed and will be provided by an enrolled provider other than the facility itself, the direct service cost shall be converted to a charge per day for that recipient. If authorized registered nurse visits are needed, the direct service cost shall be reduced so that the sum of the direct service cost and the registered nurse visit cost exceeds neither the average statewide monthly cost for care in a nursing facility determined by the Division of Medical Services nor the facility's usual and customary monthly rate for personal care services as charged to the DMH. Then the adjusted direct service cost shall be converted to a charge per day for that recipient; and

(C) The DMH shall collect logs of service and invoices from the provider and pay the provider's usual and customary rate. From the invoices and logs, the DMH shall determine the days of service delivered to each recipient and bill the Division of Medical Services for each day at the approved charge per day for each recipient. The DMH shall certify its cost to the Division of Medical Services and the Division of Medical Services shall reimburse the DMH only the federal share of the total payment amount.

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.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993; 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991; and 208.201, RSMo 1987.*

13 CSR 70-91.030 Personal Care Assistance

PURPOSE: This rule revises an existing program, known as Personal Care Assistance,

administered by the Division of Vocational Rehabilitation to permit Medicaid reimbursement for PCA services to persons who are Medicaid eligible and also meet PCA eligibility. This program will be administered according to this rule and 5 CSR 90-7.010.

(1) Persons eligible for Personal Care Assistance (PCA) under Medicaid must—

(A) Be eligible for PCA according to criteria defined in 178.662, RSMo; and

(B) Be determined eligible for Title XIX (Medicaid) by the Division of Family Services.

(2) Medicaid-eligible persons who do not meet criteria for PCA as defined in 178.662, RSMo shall be referred to the Division of Aging for assessment for personal care under 13 CSR 70-91.010.

(3) Criteria for Providers: Providers of PCA must—

(A) Have a valid participation agreement with the state Medicaid agency; and

(B) Have a valid contract with the Division of Vocational Rehabilitation (DVR) as an independent living center. The contract with DVR certifies the center is capable of providing the following services:

1. Client assessment and evaluation by a team which includes an independent living specialist, physical or occupational therapist, and a registered nurse;

2. The personal care assistance plan developed by the assessment team will be made available for review by the client's physician;

3. Maintenance of a list of qualified personal care attendants available for selection by the client; and

4. Training the client in recruitment and training of attendants as specified in 5 CSR 90-9.010.

(4) Reimbursement.

(A) The Division of Vocational Rehabilitation shall set maximum fees to be paid for personal care assistance services.

(B) The total monthly payment for personal care assistance as defined in section (3) of this rule made in behalf of an individual cannot exceed one hundred percent (100%) 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 facility/mentally retarded (ICF/MR)).

(C) The average monthly cost to the state for care in a nursing facility, as defined in 13 CSR 70-10.010(4)(Q) (excluding ICF/MR), will be established in the month of May of each state fiscal year by the Division of Medical Services which will become effective on July 1 of the following state fiscal year.

(D) One (1) hour of service equals one (1) unit.

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

AUTHORITY: sections 208.153 and 208.201, RSMo 1994. 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.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991 and 208.201, RSMo 1987.*