Home and Community Based Services
Policy Clarification Questions (PCQ) and Answers

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

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April 2026

HCBS Policy Clarification Questions

Assisted Living Facility/Residential Care Facility Personal Care

1. Can a task be authorized for a participant at a Residential Care Facility/Assisted Living Facility (RCF/ALF) requiring a continuous positive airway pressure (CPAP) machine and/or an oxygen concentrator for assistance with placing the nose piece/mask correctly and cleaning/maintaining the machine?

A. These are allowable tasks under self-administration of meds.

2. If a participant in a Residential Care Facility/Assisted Living Facility (RCF/ALF) requires meal prep time for specialized diets (e.g. diabetic meals), how should time be authorized?

A. During the development of a person-centered care plan (PCCP), staff should authorize the appropriate number of units to reflect the time it takes to prepare the specialized diet. Per Policy 3.20, Personal Care Services in a RCF/ALF are authorized to eligible residents when the needs of the resident exceed the minimum obligations of the facility pursuant to the respective licensure requirement. Provider billing should reflect time spent delivering the task.

3. If a participant in a Residential Care Facility/Assisted Living Facility (RCF/ALF) has a physician's order to check blood pressure and pulse twice daily, can this task be authorized?

A. Checking blood pressure and pulse are not authorized tasks under the Personal Care (PC) or Advanced Personal Care (APC) program. This task is one that would fall under the protective oversight of the RCF/ALF.

4. Can Nurse Visits be authorized for a participant in a Residential Care Facility/Assisted Living Facility (RCF/ALF) who needs diabetic nail care if the participant has been diagnosed in the past with diabetes, but is not currently on a diabetic diet?

A. Any supporting documentation to determine the participant's current diagnosis of diabetes (diagnosis codes in the HCBS electronic case management system, prescription, verbal conversation with physician, observation of insulin during assessment) would support the authorization of diabetic nail care. Not all individuals with diabetes follow a diabetic diet.

5. A Residential Care Facility/Assisted Living Facility (RCF/ALF) is requesting time to apply prescription eye drops and prescription ointment to a participant's eye. The participant can administer their own drops; however, they require assistance to steady the hand. Is this task reimbursable?

A. This can be authorized as non-injectable medications under Advanced Personal Care (APC) in an RCF/ALF.

6. Are staff members of a Residential Care Facility/Assisted Living Facility (RCF/ALF) allowed to be recognized as guardians of a resident if their actual guardians request to give the facility the right to make some basic health decisions concerning the resident?

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A. Guardian-signed forms that indicate the facility staff can make basic health decisions on behalf of the resident are not accepted. The guardian is appointed through the court system and DSDS will recognize the guardian that was approved/appointed by the judge only. However, it is protocol that DSDS consult facility staff when developing the person-centered care plan for a participant.

7. Can Personal Care (PC) and Advanced Personal Care (APC) be authorized to an individual who resides within a licensed group home?

A. State plan personal care services, as authorized by DSDS, can only be authorized to an individual in their own home or a licensed Residential Care Facility/Assisted Living Facility (RCF/ALF). A licensed group home does not fit the definition of "their own home" and therefore the individual would not be eligible for in-home services. This is based on the Code of State Regulation, 13 CSR 70-91.010 Personal Care Program (1)(B)1.

8. If a participant resides in a Residential Care Facility/Assisted Living Facility (RCF/ALF) and requires blood sugar monitoring for diabetes, can the task be authorized?

A. This is an allowable Advanced Personal Care (APC) task under non-injectable medications. The aide can help the participant complete the task by steadying the participant's hand for the participant to apply the skin stick, but the aide cannot complete the skin stick independently. The aide can also assist in reading the levels if needed.

9. If a participant requires assistance with a nebulizer and resides within a Residential Care Facility/Assisted Living Facility (RCF/ALF), can this task be authorized?

A. This would be an allowable authorized task under Basic Personal Care (PC) self-administration of medications. As noted in Policy 3.20, taking medications to a participant, including medication for nebulizers, so that the participant may self-administer their medications is considered an appropriate authorization of units for that purpose. The aide may carry and setup the equipment, open the medication packaging, place the medication into the nebulizer (prepackaged only), steady the participant's hand during the treatment and clean the equipment as needed. Starting the machine **must** be performed by the participant as it constitutes administration of medication. The same parameters apply regardless of service setting.

10. If a participant in a Residential Care Facility/Assisted Living Facility (RCF/ALF) has been advised by their physician to avoid concentrated sweets due to their diabetes diagnosis, but has no other dietary restrictions, can meal prep time be authorized?

A. Yes, dietary time should be authorized any time the facility goes above and beyond what they would normally prepare due to a participant's health condition.

11. Can nail care for participants who reside within a Residential Care Facility/Assisted Living Facility

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(RCF/ALF) be authorized if they are not able to trim their own nails?

A. Yes, if the participant is unable to trim their own nails, 15 minutes, once per month can be authorized under dressing/grooming.

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Advanced Personal Care

1. Is it required that a Registered Nurse (RN) assists with the Advanced Personal Care (APC) assessment with state staff during the initial assessment for eligibility conducted by state staff?

A. No, this is not required. Regulation, specifically 13 CSR 70-91.010 Personal Care Program (5)(D) in part says APC Plans must be developed by the provider RN in collaboration with the state. Two nurse visits are authorized during the first month of services for the training of the APC aide and evaluation of the adequacy of the service plan. The provider nurse communicates with DSDS during this process if the care plan is not effectively meeting the needs of the participant.

2. Are Advanced Personal Care (APC) aides authorized to apply participants' pain patches?

A. The administration of pain patches is considered administration of medication. Therefore, placement or removal of the patch is not an allowable APC task. This would be considered a nursing level task and could be performed during a regularly scheduled nurse visit. The APC aide can however help by opening the packaging, peeling the backing, or steadying the hand during the application. This assistance would be authorized under APC non-injectable meds.

3. Are Advanced Personal Care (APC) aides authorized to apply and remove compression dressings, such as medical support stockings/hosiery even if a participant is not able to remove them on their own?

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

4. If a participant needs assistance placing and removing a pneumatic compression device (an inflatable sleeve, glove, or boot designed to improve circulation), can this be authorized under Advanced Personal Care (APC)?

A. This is an allowable APC task under aseptic dressing, if the participant can deflate/remove the devices on their own accord for emergency needs of swelling, bleeding, pain, or drainage. This can also be done by a family member or friend of the participant in case of an emergency if the family member or friend is with

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

5. Under ostomy hygiene, is an Advanced Personal Care (APC) aide allowed to change the ostomy wafer when cleaning the bag?

A. Changing the wafer is a component of changing a colostomy bag process and appropriate hygiene, thus the APC aide should change the wafer as well.

6. If a participant has a stoma and requires over the counter laxatives, can the Advanced Personal Care (APC) aide mix the laxative with water and administer it via the stoma?

A. Due to the presence of the stoma, the administration of the laxative and water is not a covered service and cannot be authorized through Personal Care (PC) or APC. This would be considered a nursing level task and could be performed during a regularly scheduled nurse visit. Authorization of nurse visits are limited to 26 visits in a 6-month period.

7. Are Advanced Personal Care (APC) aides authorized to perform a Malone Integrated Continence Enema (MACE), which is an enema inserted through a port within the abdomen?

A. This can be authorized as an APC task under bowel program once the stoma site is well healed.

8. Under ostomy hygiene, are Advanced Personal Care (APC) aides allowed to suction out tracheostomies?

A. No suctioning of any kind is an allowable task under APC. It must be completed by a nurse or trained family member.

9. Are Advanced Personal Care (APC) aides authorized to clean urinary catheters and change the bag?

A. Changing the bag, as well as soap and water hygiene around the insertion site, are allowable APC tasks under catheter hygiene.

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

A. The placement of TENS unit electrodes is an approved APC task under non-injectable medications; however, the participant must turn the machine on and off themselves.

11. If a participant uses a gait belt for transferring from bed to wheelchair and vice versa and the aide uses the belt to assist with the process, is this an allowable Advanced Personal Care (APC) task?

A. Gait belts are approved to use as a transfer device for APC services. Gait belts may also be utilized at the provider's discretion for the purpose of mobility assistance (Basic Personal Care).

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12. If a participant requires a physician ordered orthotic brace, can an Advanced Personal Care (APC) aide assist in removing and replacing the brace?

A. This is an allowable APC task under aseptic dressing if the participant can remove the orthotic on their own accord for emergency needs of swelling, pain, etc. This can also be done by a family member or friend of the participant in case of an emergency if the family member or friend is with the participant for majority of the time. There should be additional nurse visits scheduled in the first month of any new APC task so the nurse can properly train/guide the APC aide.

13. With regards to the bowel program, if a participant requires assistance such as sphincter stimulation or pre-packaged enemas to prevent or assist with fecal impaction, is it ok to authorize additional time for the bowel program under Advanced Personal Care (APC)?

A. Determining the time needed to ensure a participant's needs are being met is based on the individual needs of the participant. The units should be authorized based on time necessary to complete the entire process. Both digital stimulation and/or pre-packaged enemas may be authorized under APC, bowel program.

14. If a participant needs trach care, specifically changing out the trach, can this be authorized as a task for the nurse to complete during the weekly nurse visits for med setup?

A. Yes, this is an appropriate task for the nurse to complete. If there isn't an authorization for weekly med setup, DSDS staff could authorize a weekly visit for this task under "other nursing tasks". Advanced Personal Care (APC) aides are authorized to provide tracheostomy hygiene to well-healed sites only, while changing or replacing the trach remains a nursing task. Note: It is important for providers to remember that a referral shall be made to Home Health services for the participant when appropriate.

15. What is the difference between Basic Personal Care (PC) self-administration of medication and Advanced Personal Care (APC) non-injectable medication?

A. Self-administration of medication is defined in 19 CSR 30-83.010 (46) as the act of actually taking or applying medication to oneself. For example, time spent handing the medication container and water to the participant so that the participant can self-administer their medications would be appropriately calculated in the time for this task. This would also include guiding/steadying the hand for oral medications and/or inhalants. APC non-injected medication services are defined as manual assistance with non-injectable medications and may include opening a medicine lockbox, steadying the participant's hand/arm for ear and eye drops, finger sticks etc., and when prompting is required to take medication. While the two services involve many of the same actions by the aide, the difference lies in the participant's ability to set up/know when to take their own medications.

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16. Are Advanced Personal Care (APC) aides authorized to administer vagus nerve stimulation to a participant?

A. This is not an allowable APC task.

17. Can a Prothrombin Time/International Normalized Ratio (PT/INR) blood test be authorized under Advanced Personal Care (APC)?

A. The test needs to be completed by the participant, a trained family member, or a nurse. The APC aide could steady the participant's hand and read the levels if the participant needs this assistance. This would be authorized under non-injectable medications.

18. If a participant needs prescription ointment applied to a stage II wound, can Advanced Personal Care (APC) be authorized for the application of the ointment?

A. No, all wound treatments beyond a Stage I are considered a nursing level task.

19. Are sit-to-stand (Hoyer) lift devices authorized under Advanced Personal Care (APC) for use? The device uses a belt that is placed around the participant's waist and lifts the participant to a standing position using hydraulics.

A. This type of device is considered a type of "Assistive Transfer Device" and would be authorized under APC. The provider will have to assure the APC aide is adequately trained on this device to meet the needs of the participant.

20. Is a Licensed Practical Nurse (LPN) allowed to complete both the General Health Evaluations (GHE) and the six-month Advanced Personal Care (APC) services assessment?

A. An LPN is allowed to complete the GHE visit under the direction of a Registered Nurse (RN) or physician; however, an RN must complete the six-month APC service assessments.

21. Can the application of Nystatin powder be treated the same as Nystatin Cream applications and authorized under Advanced Personal Care (APC)?

A. Yes, prescription Nystatin powder should be treated like Nystatin Cream application under APC.

22. If a participant requires the use of a nebulizer, but is not able to hold the aerator to participant's mouth for the entire length of time of the treatment, can the aide steady and hold the participant's hand so the participant can administer the medication on their own?

A. If the participant can administer their own medications, then it is an allowable task under Basic Personal Care (PC) self-administration of medications. For more details see number 9 in the Residential Care Facility/Assisted Living Facility (RCF/ALF) section.

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23. Does Missouri Medicaid Audit and Compliance (MMAC) review Advanced Personal Care (APC) tasks regarding what can be authorized?

A. DSDS authorizes specific tasks under APC authorizations and MMAC audits to ensure the provider delivered according to the authorized care plan.

24. For participants who have difficulties swallowing, can their medications be added to their food (e.g., applesauce) by the Advanced Personal Care (APC) aide?

A. If the medication has been reviewed and set up for the participant by the nurse and the participant is feeding themself then the act of emptying the medicine out of the planner into (ensuring not to touch the medication) the participant's food can be completed by the APC aide. The aide shall not alter (e.g., crush or mix) the medication.

25. Are physician orders required for Passive Range of Motion (PROM)?

A. Yes, PROM is authorized based upon the participant's needs; however, the provider must obtain a copy of the physician's orders to deliver this task appropriately.

26. Are aides allowed to disconnect and reconnect insulin pump tubing for the purpose of bathing the participant?

A. Yes, this would be an approved Advanced Personal Care task (APC) and the provider should ensure that the aide is properly trained to complete the task under non-injectable medications.

27. Regarding conditions for reimbursement for Advanced Personal Care (APC), the Personal Care Regulation (13 CSR 70-91) states, "The provider agency is responsible for obtaining the recipient's physician's approval for the plan." Can a nurse practitioner (NP) or physician assistant (PA) provide this approval?

A. Yes, DHSS and Missouri Medicaid and Compliance (MMAC) will accept approval from either a physician, NP or PA as appropriate documentation for this purpose. Additionally, a NP or PA may be accepted for any orders related to HCBS services if they fall within the scope of the NP or PA's license.

28. Do DSDS staff need to obtain a copy of Advanced Personal Care (APC) physician orders from the provider to authorize services?

A. No, this is the provider's responsibility.

29. If a participant has medication set up with hospice or home health and the provider agency is different than the In-home agency, can the personal care aide provide medication assistance to the participant?

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

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30. Is clean-up time associated with bowel program administration included within the bowel program time or authorized within toileting?

A. All steps including clean-up should be authorized under bowel program.

31. Can an Advanced Personal Care (APC) aide complete any portion of the tube feeding process?

A. No. An aide cannot complete any part of the actual tube feeding process, they may only assist in the cleanup. Meaning the aide may not be authorized to mix the solution, pour the solution in the bag, or set the machine. The aide may wash syringes, bags, or tubing after the feeding is complete. This would be authorized as dietary under In-home and wash dishes under Consumer Directed Services (CDS).

32. Can an aide assist with changing a wearable insulin pump such as an Omnipod?

A. Typically, this would be above the level of an advanced personal care aide. An advanced personal care aide can however assist with gathering the supplies and steadying the hand if needed.

HCBS Policy Clarification Questions

Assessment / Reassessment

1. What constitutes a physician ordered diet?

A. A physician ordered diet includes weighing, measuring, and/or restricting selected nutrient components. An example for someone with diabetes would be carb counting or utilizing the glycemic index to select foods per the physician's order. A physician simply recommending someone to "watch their sweets," is not a physician ordered therapeutic diet. Therefore, further information would need to be gathered to see if the participant has been restricted to a certain limitation.

2. If a participant is due for a provider reassessment and their home is in poor condition and/or there is an infestation, can the provider conduct the reassessment in the office and bill for the assessment?

A. It is preferred the reassessment be conducted in the participant's home; however, this is not a requirement and there may be circumstances where a reassessment could be conducted elsewhere if the participant is agreeable. This must be documented in case notes. Provider staff should work with DSDS staff to ensure there is a plan to address the issues with the home. Additionally, if a participant is currently in the hospital, it is appropriate to conduct the reassessment as part of the discharge planning process at the hospital if the participant is agreeable.

3. With the recent Office of Administration (OA) changes made for DSDS Staff requirements, what degrees would be acceptable and qualify an HCBS provider to participate in the reassessment process??

A. All HCBS providers must ensure assessors have a bachelor's degree in any field or be a Registered Nurse or License Practical Nurse licensed in the State of Missouri or four (4) years working for Division of Senior and Disability Services or four (4) years working for an Area Agency on Aging or be multi-lingual and approved through DSDS.

4. If the participant is receiving oral chemotherapy treatment, where should it be recorded in the interRAI HC for determining Level of Care (LOC)?

A. Chemotherapy treatments are defined in Section N: Treatment and Procedures, but when the medication is administered orally and not intravenously, it must be recorded in Section M: Medication, as well.

5. Are providers required to keep paper copies of the forms used for a reassessment that they complete?

A. It is not necessary to keep paper records used to conduct a reassessment, however, all documentation must be recorded in the HCBS electronic case management system.

6. Can you define walking versus locomotion?

A. Locomotion is defined as: ability to move from one place to another. If in a wheelchair, self-sufficiency once in their chair.

Walking is defined as: movement at a regular pace by lifting and setting down each foot in turn, never having both feet off the ground at once.

7. Where do we document injections on the assessment?

A. Injections are a means to administer medications; therefore, the medication in the injection would be documented in Section M of the interRAI HC. Additionally, the assessor would document the participant's ability to administer the injections in Section G1d.

8. If we are denying Consumer Directed Services (CDS) based on inability to self-direct, does Behavioral Level of Care (LOC) need to be a 9?

A. No, the assessor should accurately code the interRAI questions and ensure that SLUMS, Self-Direction Assessment Questions, information from a health care professional (see the Healthcare Professional Inquiry Form), and any other documentation (when considered in totality) support the decision regarding self-direction.

9. Does an assessor only mark yes to the Legal Guardian question if they have the supporting documents in the attachments?

A. No, the assessor should answer the questions accurately and make every effort to gather the documentation later.

10. If a participant no longer has a guardian, what action should the assessor take?

A. The "Contact" section in the participant's electronic case record should be updated, and a case note entered. When available, dismissal paperwork should be attached to the participant's electronic case record.

11. Should the reference date be the day you were in the home for the assessment?

A. Yes.

12. During the assessment, is it acceptable to ask the questions in a different order than they appear in the InterRAI HC?

A. Yes, it may be beneficial to ask some questions out of order. For example, before answering questions in Section G regarding physical abilities, the assessor might want to ask the participant to get their current medications. This will allow the assessor to observe their ability to ambulate.

13. How is smokeless tobacco documented (chewing tobacco or vapor cigarettes)?

A. Smokeless tobacco is not included in the assessment.

14. Do we document in case notes the observations we made that are different from what the participant reports?

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A. Yes, the assessor can gather information from observations and through collateral contacts change the coding in the InterRAI HC to accurately reflect the condition of the participant.

15. Where can assessments be conducted? If a participant is in the hospital at the time of the assessment, do participants need to be seen in the home or can it be in the hospital?

A. Assessments are to be completed in the home. When there is an urgent need of services, a participant can be seen in the hospital to expedite the authorization of Home and Community Based Services (HCBS). However, a follow-up visit in the home should be made to validate the assessment and the previously completed care plan.

16. If a participant resides in a Residential Care Facility/Assisted Living Facility (RCF/ALF), how should the assessor code meal preparation in section G4a?

A. Performance should be coded as a 6 – total dependence, and capacity should be coded based upon the participant's presumed ability.

17. If a participant can use a microwave or make a sandwich; how is capacity coded in section G4a?

A. Meal preparation should be coded based on the person's ability to put meals together, regardless of the nutritional value of the meal. For example, if the person is able to make cold cereal or a sandwich without assistance, the person would be scored as independent in meal preparation capacity. However, we must look at their true ability. If a participant simply does not like to cook or feels that is the job of someone else but is capable of safely cooking, the participant should be coded as independent.

18. If a participant can bathe themselves, but must have someone present (fall risk, seizure prone), how is this coded in section G5a?

A. Participants only needing standby assistance (no hands-on assistance) should be coded as 2 – Supervision. If the participant requires hands on assistance, the assistance should be scored based on the amount of weight bearing assistance needed.

19. If a participant only needs help getting in and out of the tub, how is this coded in section G5b?

A. This answer depends on the level of weight-bearing support that is required. The assessor may need to gather information from the caregiver(s) to determine this information.

20. Should stress incontinence be considered in Section H?

A. Yes

21. If a participant with a developmental disability becomes preoccupied in certain situations and is incontinent as a result, how is this scored in section H?

A. Section H should be coded based on the frequency of the incontinence regardless of the circumstances.

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22. If a participant is a quadriplegic or paraplegic, how is this coded in J4 – Balance?

A. J4a – Difficult or unable to move self to standing position unassisted would be scored as 4 – Exhibited Daily
J4b – Difficult or unable to turn self around and face the opposite direction when standing would be scored as 4 – Exhibited Daily.
J4d – Unsteady Gait would be scored as 0 – not present as this individual is not able to display a gait.

23. Are inhalers counted as medication?

A. Yes. Inhalers count as a medication and are not coded as "Other respiratory therapies".

24. How do we count the meds that are "taken as needed"?

A. Per regulation, medications taken as (PRN) are counted if they have been taken in the last thirty days.

25. If a treatment involves the use of a medication (e.g. nebulizer, chemotherapy) should the medication be counted in Section M in addition to being scored in Section N?

A. Yes, if the medication has been taken in the last 3 days or on a regular maintenance schedule.

26. Are herbal supplements counted?

A. Prescribed herbal supplements are to be counted in M1. Non-prescribed herbal supplements are to be counted in M2.

27. If the participant refuses to show the assessor their medications, should they be counted in section M.

A. Medications should only be counted if they can be verified. If the assessor is unable to do this in the home, other means can be utilized such as information in the HCBS electronic case management system or contact with the pharmacy or physician.

28. If chemotherapy treatments are done every couple weeks or at a more spaced out schedule, how is this coded in Section N2?

A. This would be coded as a 1 – ordered, not yet implemented, unless their treatment occurred within the last three days, in which case it would be coded a 3 – 1-2 of last 3 days. Ordered chemotherapy will produce the same LOC score regardless of how often it is received. Case note clarification should be provided to further explain the situation.

29. How is tele-monitoring scored?

A. Telemonitoring is to be coded in N8 based upon the stability of the participant and the frequency of the monitoring. The LOC score would vary depending on stability and frequency coded.

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30. Are chiropractic services considered a treatment?

A. No

31. How would an assessor code if physical therapy is ordered, but the participant refuses to attend the sessions or if sessions have not yet begun?

A. If a participant has a physician's order for PT, but is choosing not to attend, the need is still there. Therefore, the assessor would put a "1" for Physical Therapy in Section N3e, column A (days). The coding would be the same if the PT order is new and the sessions have not started by the time of the assessment. Both situations would need to be documented in case notes.

32. If a participant is being monitored by a health professional for a mental health condition, what credentials does the health professional need to have for that participant to receive points in section N8 monitoring?

A. The health professional must be a licensed mental health professional or be a physician.

33. If a participant resides in a Residential Care Facility/Assisted Living Facility (RCF/ALF) and the facility disperses all medications to the residents, how should this be scored under performance on question G4d – Managing Medications?

A. If the participant remembers when to take their medications and goes to the medication dispersion area without being prompted, then score as a 5 – Maximal Assistance. If the participant does not remember when to take their medications and relies completely on the facility for medication management, score as a 6 – Total Dependence.

34. In Section I – Disease Diagnoses, when is it appropriate to code a diagnosis as 1 vs 2?

A. 1 – Primary diagnosis/diagnoses for current stay should be used for the primary reason the participant needs services. The term "current stay" is often confused as hospital or facility stay but should instead be seen as the reason for services. 2 – Diagnosis present, receiving active treatment should be used for other diagnoses that the participant is receiving treatment for but that are not the primary reason services are needed.

Ex: A participant just had a stroke and now has paralysis on the right side of their body. They also have diabetes and depression. The participant receives treatment or takes medications for all diagnoses but up until the stroke the participant was able to perform all activities on their own with the diabetes and depression. In this scenario "stroke" would be coded as 1 as this is the primary reason the participant is now requesting services. Diabetes and depression would be coded as a 2 as they are receiving active treatment, but they are not what led to the need of services.

35. How does an assessor code the following treatments? Are they scored under treatments (N2), medications (M1) or both?

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A. **Pain Pump:** Both. The medication for the pain pump would be coded under M1 if used in the last 3 days or on a regular maintenance schedule. The pump would be coded under N2 as an IV medication.

Insulin Pump: Medications. The medication for the pump would be coded under M1 if used in the last 3 days or on a regular maintenance schedule. By only coding under medications, this allows insulin regimens (shots, pump, oral) to be scored the same way.

36. If a participant with balance and/or gait issues reports a near fall in the last 30 days but states they luckily caught themselves on a wall or furniture before hitting the ground, is this coded in question J1 - falls?

A. Yes, if a person would have fallen to the ground had it not been for the luck of something catching them, this would be considered a fall.

37. If a participant must brace/push themselves out of seated position using the chair arms or requires assistance of a cane/walker, is this coded as difficult to stand in section J4a even though they are able to complete the task without assistance of another individual.

A. Yes, if the participant is unable to rise without the weight bearing assistance of the device or chair. However, participant self-reporting should not be the only consideration when coding. Assessors should also use their observations, information gathered throughout the assessment, and diagnosis listed to make a reasonable determination if this task can be completed **safely**. Using the arm of the chair to assist oneself in standing does not necessarily mean they are not capable of safely standing, as it is common for a typical participant to use the arm of a chair to brace themselves when standing. Asking follow-up questions will also help get a better idea of the participant's ability to stand from a seated position. E.g. Does the participant have to use another device or furniture or person to bear weight to stand? Do they have to rock back in forth to gain momentum to get up? Do they have to make several attempts at getting up before they are able to stand?

38. What constitutes wound care in question N2j?

A. The skin must be broken for the assessor to code wound care. Broken skin refers to any condition where the skin is not intact which increases the risk of infection. Even if a scab has developed, the skin would be considered broken since the wound is still present underneath the scab. There are a variety of causes for broken skin such as a severe rash, injury, undergoing medical treatment/surgery, etc.

Application of ointments/creams to unbroken skin or rashes would not qualify as wound care. For example, applying lotion to dry skin would not be coded as wound care. Prescription ointment/creams used for treating unbroken skin should also be coded in section M1 if used in the last 3 days or on a regular maintenance schedule.

39. If a participant is self-treating their wound and has a prescribed wound care regimen from their physician, is this considered wound care?

A. Yes, if they have been prescribed a wound care regimen from their physician on how to treat their wound, then it is considered wound care. If an ointment/cream is prescribed, it would also be counted in Section M.

40. If a participant requires the support of a handrail and a break when climbing a flight of stairs, how should this be coded in section G4f-stairs?

A. If the participant can safely complete the task without assistance, this should be coded as independent. If there is concern for, safety the participant should be scored at the amount of assistance needed to eliminate the concern for safety.

41. If a participant does not have a car or license (but is physically/mentally capable of having one), how does this information impact coding in section G4i (transportation)?

A. Section G looks at the participant's ability. The lack of a car or license is a resource issue and should not be considered in the coding of this question.

42. If a participant needs assistance with nail care, can this be coded in section G5c-personal hygiene?

A. No. Section G5 only captures activities of daily living (ADL). Because nail care is usually only completed once a month, it would not be captured as an ADL.

43. If a participant only needs help with buttons, snaps, bra clasp, etc. due to dexterity difficulty, how should this be coded in section G5d-dressing upper body?

A. If there is no need for weight bearing support, this should be coded as 3-limited assistance.

44. If a participant only needs help with shoes and socks, how should this be coded in section G5e-dressing lower body?

A. If there is no need for weight bearing support this should be coded as 3-limited assistance.

45. If a participant lives in a Residential Care Facility (RCF) or Assisted Living Facility (ALF), how should this be coded for questions A12 and B5?

A. If the participant lives in a RCF/ALF, A12 – Residential/Living Status should be coded as 2 – Assisted living/ semi-independent living/ board and care. "Other" should not be selected for either of these facility types.

B5 – Residential History of board and care home, assisted living should be coded as 1-yes. These two questions should align if the participant is currently residing in a facility.

46. If a participant utilizes a prepackaged medication set up from the pharmacy, how should this be coded in G4d-Managing Medications?

A. If a participant does this simply for convenience but can manage them on their own, code as 0-Independent. If the participant needs medication set up and could not manage on their own this should

be coded as 4-extensive assistance only help only if they are able to do the rest of the medication administration process after the pharmacy set up. If additional help is needed with medications the participant should be coded at the appropriate level.

47. Should fluid restrictions be counted under K2e – physician ordered diet?

A. Yes, if the fluid restriction is physician ordered outlining a specific amount of fluid that may be taken in each day. Fluid restrictions are commonly prescribed to participants diagnosed with congestive heart failure and end stage renal disease.

48. How should a female external catheter (Purewick) be coded in section H2?

A. This should be coded as a 1 – condom catheter as both are considered to be external catheters. Further clarification should be provided in case notes.

HCBS Policy Clarification Questions

Authorized Nurse Visits

1. Do Authorized Nurse Visits need to remain strict with a certain day allotted each week for the visit?

A. There is no requirement that the nurse visit be no sooner than every seven days. The nurse visits should be completed based upon the needs of the participant.

2. If participants request to have the current week and back-up medicine planner filled in the event there is inclement weather or physician appointments, is this allowed under the Authorized Nurse Visits program?

A. There are no restrictions against filling a backup medicine planner.

3. If a participant does not have home health and is requesting Authorized Nurse Visits for assistance flushing out a port, is this a task that can be authorized under other nursing services?

A. This would be an allowable task under "other nursing services." Please remember when authorizing this service, only 26 units in a 6-month time period is allotted for nurse visits. If the port must be flushed more than once a week over a 6-month period, there would not be enough nurse visits to cover the task. Home health would then be more appropriate for this task.

4. Can nurse visits be authorized for oversight of an Advanced Respite aide for a participant who has Aged and Disabled Waiver (ADW) services, Advanced Respite and Basic Personal Care (PC) for medication assistance and nail care, but not an Advanced Personal Care (APC) authorization?

A. No. Nurse visits should only be authorized when there is an identified nursing need or if there is an APC authorization. Nurse visits should not be authorized just for the oversight of an Advanced Respite Care aide or to assure the Advanced Respite Care aide is adequately trained. This does not negate the provider's responsibility for oversight and training for aides delivering Advanced Respite.

5. If a participant is receiving home health and all weekly/monthly tasks authorized by DSDS are being performed by the home health nurse, should the provider complete a General Health Evaluation (GHE) during the month?

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

HCBS Policy Clarification Questions

6. If a participant has two different providers in the home, one delivering services in the morning and the other in the afternoons and on weekends, and both are providing Advanced Personal Care (APC), is it permissible to authorize nurse visits for the purpose of APC oversight to each of the providers?

A. Yes, however, the authorization may not exceed the limit of 26 units within a 6-month timeframe.

7. Can nurse visits be authorized more frequently than once per week?

A. Yes, nurse visits may be authorized as often as needed but the provider may not exceed 26 visits in a 6-month time period. Other nurse sources such as home health should be explored as they may be a better fit, however if that is not an option, short term frequent visits may be authorized. This would not be an ideal option for a participant that needs other weekly visits throughout the year such as medication set up as this will leave them with weeks without any leftover visits available to complete the task. Case note clarification is needed to explain the situation and insure over authorizations do not occur. The provider should be reminded to not exceed the 26-visit limit. Participants only accessing the nurse visits for a short team need such as dressing changes should only be authorized for the number of weeks, they are needing the services. For example: If someone needs dressing changes 4 times per week, they should only be authorized for 6 weeks as after that 6th week they exceed the visit limit.

8. If a participant is on an aspirin regimen, does this constitute a medical need for authorized nurse visits for nail care?

A. No. Nail care in this instance should be authorized under dressing and grooming unless there is a physician's order or another medical condition that constitutes the need for a nurse to provide nail care. Advanced anticoagulant therapies such as Coumadin do however indicate a need for nurse authorization.

9. Do tremors constitute a medical need for authorized nurse visits for nail care?

A. Not necessarily. A physician must indicate a need through an order for a nurse to complete the task.

10. What does "other medically contraindicating conditions" refer to when deciding if a participant is eligible for diabetic nail care?

A. Medically contraindicating conditions are health conditions or factors that make a specific treatment, medication, procedure, or activity unsafe for a person. Diabetic nail care may be authorized when a participant has a condition that requires specialized attention, such as the use of anticoagulant medications (e.g., Coumadin), a diagnosis of peripheral vascular disease, a compromised immune system (e.g., HIV or individuals undergoing chemotherapy), or other medical conditions that cause foot or nail deformities. Documentation must clearly describe the health condition and explain why specialized assistance is required. However, if the participant is still able to safely and independently complete nail care despite these diagnoses, time should not be authorized.

HCBS Policy Clarification Questions

11. When can authorized nurse visits be used for an acute situation, such as wound care?

A. Participants may be authorized for nurse visits for specific tasks when the needs of the participant cannot be met and are not reimbursable through the home health program. Meaning the participant must be denied or unable to receive home health. DSDS staff should ensure this is accurate information by checking with the physician before authorizing. This will only occur in rare instances. Thorough documentation should be provided in the case notes.

12. Can vaccines be provided during Authorized Nurse Visits? If so, does a one-time authorization need to be added to the care plan for the task to be completed?

A. Yes, vaccines may be completed during nurse visits if there is a physician order. If a participant already has regularly scheduled nurse visits (ex: med setup), the vaccine should occur at the regularly scheduled visit and a one-time authorization to the care plan shall not be added. If a participant does not have regular nurse visits; a one-time authorization will need to be added to allow the provider to bill for the nurse visit. Providers do not need to contact the PCCP team to notify them of vaccine administration unless a one-time visit authorization is needed.

13. How are the 26 visits per 6 months counted? Is this based on a calendar or assessment year?

A. Assessment year. The first 6 months following the authorization period, and then the second 6 months of the authorization period.

HCBS Policy Clarification Questions

Consumer Directed Services

1. If a potential participant has a Power of Attorney (POA) does this make him or her ineligible for Consumer Directed Services (CDS)?

A. The fact that the potential participant has a Power of Attorney does not make the participant ineligible for CDS. The potential participant must have the ability to self-direct their own care to qualify for CDS.

2. Once authorized when must services start for Consumer Directed Services (CDS)?

A. There is no timeframe established in Statute or Regulation for the CDS model, however, it is the responsibility of the provider to maintain a list of eligible attendants in cases of participants needing immediate care, etc.

3. Is an attendant allowed to provide Consumer Directed Services (CDS) to a participant while out of state?

A. Currently, there is nothing in regulation which says an attendant cannot be paid or is not allowed to provide services to the consumer out of state. It's reasonable to assume that a CDS participant who needs assistance with personal care at home would also need care when he/she travels to another location. The provider must still be able to ensure appropriate delivery of services, and the travel out of state must be temporary.

4. If a participant is in a same-sex marriage and qualifies for Consumer Directed Services (CDS), can the spouse work as the attendant for the consumer?

A. Missouri recognizes same sex marriages; spouses cannot be the paid CDS attendant.

5. Is it possible to have two Consumer Directed Services (CDS) attendants in the home of a participant who is receiving chemo and sleeps most of the day, to perform personal care tasks at a quicker pace, so not to disrupt the participant while they are sleeping?

A. It is not a possibility due to the one service code per participant at one time requirement for Medicaid billing. Even though the attendants would perform different tasks, it would fall under the CDS billing code.

However, it is possible to have two direct service workers in the home at one time if they are performing different "service types". For example, CDS cleaning tasks and nurse visits.

6. Does the 21-day rule regarding advance notice to the participant prior to discontinuing services pertain to Consumer Directed Services (CDS)?

A. No, it does not. Below is the applicable regulation regarding discontinuation of services in the CDS program.

(7) Vendors, after notice to DHSS—

(A) May suspend services to consumers in the following circumstances:

1. The inability of the consumer to self-direct;
2. Falsification of records, falsification of condition, or fraud;
3. Persistent actions by the consumer of noncompliance with the plan of care;
4. The consumer or a member of the consumer's household threatens or abuses the attendant and/or vendor; and/or
5. The attendant is not providing services as set forth in the plan of care and attempts to remedy the situation have been unsuccessful; and

(B) Shall provide written notice to DHSS and the consumer listing specific reasons for requesting closure or termination. All supporting documentation shall be maintained in the consumer's case file. DHSS shall investigate the circumstances reported by the vendor and assist the consumer in accessing appropriate care. Upon a finding that such circumstances exist, DHSS may close or terminate services.

7. Are physician orders required for Consumer Directed Services (CDS) participants with Advanced Personal Care (APC) type tasks (e.g., passive range of motion)?

A. This is not a requirement of the regulation under CDS.

8. Is it acceptable for a Consumer Directed Services (CDS) attendant to be listed as a consumer's payee?

A. Only legally responsible individuals (court appointed guardian or conservator) and spouses are prohibited from being an attendant in the CDS program. There is nothing that prohibits a payee from being an attendant, however, the provider may want to include more oversight in this type of case and the provider always has the right to create more restrictions than required by statute and regulation.

9. Are Consumer Directed Services (CDS) consumers allowed to use all their "daily" units each month regardless of whether it is a "short" month?

A. Missouri Medicaid Audit and Compliance's (MMAC) expectation is that anything billed needs to be authorized, delivered, and adequately documented. In certain circumstances, the participant may need to use more services in a certain day, thus utilizing all their monthly units in a short month. The provider shall document, and bill as delivered (for example, the participant has the stomach flu and needs extra bathing time and toileting time).

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

A. Regulations state that CDS providers must perform "case management activities with the participant at least monthly to provide ongoing monitoring of the provision of services in the plan of care and other services as needed to live independently". Please refer to VM-07-18 Vendor Oversight for detailed information regarding this requirement. There is also a service in ILW entitled Case Management. This service is defined as "service that assists participants in gaining access to needed Waiver and other State

Plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained."

Case Management through the ILW includes:

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

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

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

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

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

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

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

14. If a participant needs technical assistance with telehealth calls, can time be authorized under essential correspondence?

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

15. If a participant is requesting application of non-prescription ointment/cream, what CDS task would this be authorized as in the care plan?

A. This would be included with treatments.

16. Why are participants not allowed to have both Division of Senior and Disability Services (DSDS) Consumer Directed Services (CDS) and Department of Mental Health (DMH) Self-Directed Services (SDS) at the same time?

HCBS Policy Clarification Questions

A. When entering a consumer directed or self-directed model, the participant is the employer however a financial management service (FMS) provider is required to act as the fiscal intermediary between the participant (employer) and the Medicaid claiming system. The DSDS CDS program allows each CDS provider to act as the FMS provider while DMH has contract with a specific FMS entity. If a participant were in both programs, they would be required to work with two different FMS entities to process payments. The IRS only allows one FMS to file payroll, employment, and other taxes per Employee Identification Number (EIN) and the participant can only have one EIN. This means the participant must decide between CDS and SDS to be in compliance with the IRS. DSDS does not need to send an adverse action to the participant.

17. Can an employee of a Consumer Directed Services (CDS) agency also be a personal care attendant?

A. Per regulation, an owner and direct employee of the CDS agency who performs any of the office tasks below and/or individuals who perform reassessments (state designee) cannot be an attendant for any of that agency's participants due to a conflict of interest, unless the attendant provides services solely on a temporary basis on no more than three days in a thirty-day period. These records shall be maintained by the certified manager and provided to MMAC upon request.

- Performs the annual face-to-face
- Performs any case management
- Processes EVV (reviews, manual edits, aggregator, etc.)
- Processes MO HealthNet claims/payments

18. Can a Consumer Directed Services (CDS) agency provide services to a participant without having the participant's Employee Identification Number (EIN)?

A. No. CDS agencies must ensure EINs are obtained and uploaded into the participant's electronic case record before they can deliver services.

HCBS Policy Clarification Questions

Consumer Directed Services/Transportation (Essential Transportation)

1. Is transporting to reading classes for reading comprehension allowable?

A. Yes, this is considered "continuing education" and is allowable under essential transportation.

2. Is transporting for events such as: visiting another individual's home for social visits, or visiting someone in the hospital or a church/church function allowable?

A. Social activities are not appropriate as they do not meet the definition of essential transportation. This does not mean that the attendant cannot take them to the destination and deliver appropriate and authorized personal care tasks while the participant is in that location. The transportation may not be reimbursable, but the personal care is.

3. Is transporting to a funeral home to make funeral arrangements for someone else allowable?

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

4. Is transporting to an appointment to have blood drawn for lab work (when Medicaid does not pay for the service, and it is performed separately from a physician visit) allowable?

A. Trips for medical appointments or health-oriented appointments (lab draws, chiropractor, etc.) are always considered to be appropriate tasks for essential transportation as long as it is not a Non-Emergency Medical Transportation (NEMT) covered trip.

5. If a participant is a wheelchair user and unable to transfer to and from or assist in placing their wheelchair in the vehicle without assistance, and Non-Emergency Medical Transportation (NEMT) is not assisting, can essential transportation be authorized?

A. No, the participant should submit a complaint through MO HealthNet regarding this issue. Problems with an NEMT provided service is not justification to authorize the service through Consumer Directed Services (CDS).

6. Is transporting to a storage unit or facility for the purpose of relocating possessions from a home as ordered by the participant's landlord or owner of property or face eviction allowable?

A. Yes, this would be considered 'essential' since removing the items is necessary so the participant can remain in the home.

7. Can a participant have a family member or friend ride along?

A. This is a decision between the provider, attendant, and consumer. DHSS does not have a regulation prohibiting this practice.

HCBS Policy Clarification Questions

8. If two participants live in same household and both are authorized for transportation and prefer to conduct joint shopping for groceries, can the attendant enter the first 30 minutes for one participant and second half hour for the second participant, to save the attendant from having to make two trips to the store?

A. Yes, it is appropriate to document this way if the times do not overlap one another, and the participants' needs are being met.

9. Is transporting to physical therapy sessions (including aquatic) allowable?

A. Non-Emergency Medical Transportation (NEMT) must be utilized prior to Consumer Directed Services (CDS) transportation. If the participant discovers the physical therapy does not qualify for NEMT, the attendant can transport the participant to and from the physical therapy appointment. However, while the participant is with the physical therapist, any time the attendant spends waiting for the participant to complete the therapy session cannot be reimbursed.

10. Can Non-Emergency Medical Transportation (NEMT) providers transport the participant and their attendant as a "rider" for assistance needed during medical appointments (mobility concerns of participant)? Will the attendant need to pay for their transport spot? If not, who is responsible for the cost?

A. The NEMT broker would be able to take the participant and an additional rider. It would need to be conveyed that the participant would need the additional rider at the time the reservation is made. The participant would be the only one that would be asked to pay copay for the transportation and not the additional rider.

11. Are attendants allowed to run errands (grocery shopping, pharmacy, etc.) on behalf of the participant by means of public bus transportation?

A. There is nothing in statute or regulation which prohibits this or requires the use of the attendant's personal vehicle. In some instances, a taxi has been used.

12. Can an attendant complete all necessary shopping/errands for the participant without the participant accompanying them?

A. Yes, Policy 3.25 Personal Care Assistance – State Plan (Consumer Directed Services Model), states that all essential shopping/errands (whether or not the participant is with the attendant) are covered services.

13. Can time spent driving the participant to and from their place of employment be authorized for transportation?

A. Yes, Policy 3.25 Personal Care Assistance – State Plan (Consumer Directed Services Model), defines essential transportation as all essential shopping/errands (whether or not the participant is with the

attendant), medical appointments not covered under the Non-Emergency Medical Transportation (NEMT) program, school, or employment, etc.

14. Do either appointments for PT/OT or appointments across state lines indicate an automatic denial for Non-Emergency Medical Transportation (NEMT) and verify a need for essential transportation?

A. Neither of these scenarios are listed on NEMT's site as trips that would automatically be denied. DSDS staff/participant should confirm with NEMT before authorizing essential transportation in these 2 scenarios.

15. If a participant's groceries are bought at the same time as the household's, can this time be authorized under essential transportation?

A. If the purchased items are a benefit to others in the household, time cannot be authorized for the shopping of these items.

16. Is it allowable to give additional time for Essential Transportation to travel to a nearby city or town to shop for essential items?

A. Yes, this is allowable. In rural areas, chain stores in a nearby city or town may be more cost-effective than local stores. However, the location of these stores should be reasonable for where the participant lives. It is not allowable to travel further out of preference if a practical option is available and closer in proximity. Essential transportation is a service for the participant that is essential to their day-to-day needs, not for others within or outside of the household. It is also important to note that online ordering should be considered as an alternative option.

HCBS Policy Clarification Questions

General

1. Is assisting with homework an authorized task under essential correspondence?

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

2. If a participant has a service dog, is it allowable for the aide to take the dog for walks/to potty?

A. These are not allowable tasks and cannot be authorized and added to the participant's care plan.

3. If a provider requests the name and DCN of a potential participant to review the participant's case history to determine if they are willing to accept the participant, is it acceptable for DSDS staff to provide the DCN to the provider?

A. Yes, this gives them a chance to review the care needs, history and potential safety concerns and make an informed decision as to whether or not to serve the participant. Please verify with the participant that they are interested in this potential provider before releasing the information.

4. Are DSDS staff allowed to tell providers that the participant they are assisting is on the sex offender registry?

A. If DSDS staff has knowledge, they may share this with the provider. Additionally, information regarding sex offender status is considered a safety issue and can be documented in case notes.

5. If a participant does not utilize all authorized weekly units, can the provider schedule the time missed in that week or any time prior to the months end?

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

6. Can 5th week hours be scheduled in shorter months?

A. 5th week hours should not be scheduled in months with four weeks but can be utilized if necessary and documented appropriately.

HCBS Policy Clarification Questions

7. When the actual delivery of services does not match the amount of time authorized for that specific task, how should units be billed?

A. Authorized units are developed through a person-centered care planning process with the participant to reflect the time necessary to complete the tasks. The suggested times and frequencies of tasks are suggestions which provide a guide for DSDS staff to develop an appropriate care plan to address unmet needs of the participant. Because the minutes to complete the task do not always equal exact unit increments, the electronic case management system automatically calculates to a full unit and allows providers to have enough time to complete all task times and frequencies in the care plan. Providers should document the time spent delivering the services and bill accordingly.

8. If a participant needs help packing their belongings due to an eviction notice, can additional time be authorized to assist?

A. To help the participant pack due to an eviction notice can only be authorized as a Chore task. Authorizations for chore tasks are funded through the Aged and Disabled Waiver (ADW) only. If the participant is not eligible for ADW services, a hotline should be made to address the situation.

9. Are providers required to conduct tuberculosis (TB) testing on their aides providing HCBS?

A. There is nothing in regulation that requires In-Home or CDS providers to complete TB testing on their staff. However, providers must report any communicable disease, which includes TB, in accordance with 19 CSR 20.20.020.

10. Can a participant be in multiple HCBS Waiver programs?

A. No. Participants cannot be authorized for multiple HCBS Waivers, regardless of which state agency administers the other waiver.

11. Can the required on the job training be in a classroom style setting instead of in the participant's home?

A. The Personal Care (PC) manual explains the designated trainer(s) may perform training during an on-site visit to a participant or in a classroom demonstration if it is performed within 30 days of the first date of employment.

12. Can the required New Employee Orientation Training for provider agencies be held via Skype or other live online video training platforms?

A. For the required eight hours of classroom training and Advanced Personal Care (APC) oversight, as noted in 13 CSR 70-91, the use of a video platform, such as Skype, for this portion of the training would be allowed.

13. If a Family Care Safety Registry (FCSR) finding is no longer a disqualifier, will it still show up on the background screening?

A. Yes. The FSCR is required by statute to report all findings that show up on the background screening, not just those that may disqualify the registrant. It will be the responsibility of the employer/provider to compare the screening results to the list of disqualifiers outlined in Section 192.2495, RSMo, to determine whether or not the employee is eligible. If a provider/employer has questions about eligibility, they will need to check with their respective regulatory or contracting unit(s). FSCR is not authorized to make eligibility determinations or to advise providers regarding statutory, regulatory or contractual requirements. Providers who contact the FCSR with these types of questions will be redirected to their respective regulatory or contracting units, as they are currently.

14. If a person has a background finding that is not a disqualifier, but the employer is uncomfortable based on the finding, will the Good Cause Waiver panel make a decision on behalf of the employer?

A. No. The hiring decision is the responsibility of the employer. The DHSS panel is authorized to make Good Cause Waiver decisions only regarding applicants who are disqualified based on the background screening findings listed in statute. If a Good Cause Waiver application is received for an individual who is not disqualified based on what is listed in statute, the application will be rejected (e.g., will not be considered) and the applicant and/or employer will be notified. The hiring decision always remains with the employer/provider, even if a finding is not a disqualifier, there are no findings, or the applicant has a Good Cause Waiver. For example, an applicant may not have a felony theft on their record but has a string of misdemeanor and/or local ordinance thefts. Even though the applicant would not be disqualified per statute, the provider might still make the decision not to hire due to the pattern of "lesser" thefts.

15. Is an employer/provider required to request the status of a Good Cause Waiver prior to hiring an employee who currently has a waiver on file, but does NOT have a disqualifying finding?

A. No. It is recommended the employer/provider request a current background screening from the Family Care Safety Registry and compare the screening results to the list of disqualifiers outlined in Section 192.2495, RSMo, to confirm if the employee is eligible for hire. Questions regarding eligibility should be directed to the employer/provider's regulatory or contracting unit(s). The hiring decision always remains with the employer/provider.

16. If an HCBS provider employee tests positive for THC and presents a medical marijuana certificate from a physician is the employee allowed to perform their work?

A. It is ultimately the provider agency's responsibility to decide their own employment policies and practices in relation to this subject matter. The provider's policies and practices should be guided by their interpretation of Missouri's constitution, patient rights, and may be subject to continued case law interpretation. If it is not in the best interest due to the nature of the work", an employer may choose not to employ people who have tested positive for THC, regardless if they have a prescription or not.

HCBS Policy Clarification Questions

17. Does HCBS allow the authorization of any type of assistance with Medical Marijuana?

A. No. Medical marijuana is not legal under federal law and cannot be authorized under any service type.

HCBS Policy Clarification Questions

Agency Model Personal Care (In-Home Services)

1. Once authorized in the HCBS electronic case management system when must services start for In-Home Services?

A. Regulation requires the provider shall begin providing services within 10 days of receipt of the care plan and acceptance of the participant.

2. If a participant requires tube feeding, is the aide allowed to physically hang the bag for the participant if they are not able to do so themselves?

A. No, any assistance with tube feeding requires the assistance of a nurse or trained family member.

3. Can a family member become the in-home aide for a participant?

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

4. How are the areas within a participant's home that need to be cleaned and picked up determined and what specifically is the aide responsible for cleaning?

A. Per 19 CSR 15-7, "The range of homemaker, chore, and respite activities the in-home worker provides is mutually determined by the provider agency and the client." Home and Community Based Services (HCBS) is person-centered and therefore, each participant's specific circumstances, living arrangements, home conditions, abilities, and unmet needs should be assessed when making this determination.

5. Can a great grandchild become the in-home aide for a participant?

A. There is no regulation stating great grandchildren are prohibited from becoming the aide and it is allowed so long as the provider agency approves.

6. Is the use of a signature stamp allowed for a participant who is unable to physically sign their name?

A. Yes, the use of a signature stamp is allowed in the event the participant is not able to sign their own name. Pursuant to 13 CSR 70-91, for each date of service the signature or mark of the recipient must be recorded.

7. Is a General Health Evaluation (GHE) required if the participant has only Personal Care (PC), medically related household tasks authorized?

A. Yes, the GHE shall be authorized for all state plan agency model participants. Policy 3.15 Authorized Nurse Visits- State Plan-Agency Model states GHE (for purposes of the semi-annual nurse visits) shall be selected as a task for participants when no other nursing need is identified.

HCBS Policy Clarification Questions

8. What is the standard time allowed per meal without any additional accommodations needed?

A. The suggested times and frequency for dietary noted is 10-60 minutes, 1-7x/week. See Policy 3.05 Basic Personal Care for all suggested times and frequencies. The suggested times and frequencies are provided for these tasks as a tool to help facilitate a conversation between the participant and DSDS staff or designee. The time required to complete a task is mutually identified and agreed upon. If the time to complete a task varies greatly from the suggested time and frequency in a particular care plan, the reasons for the deviation shall be documented in case notes. See Policy 4.20 Person Centered Care Planning and Maintenance for additional guidance.

9. If the participant needs a haircut, is it allowable under Personal Care (PC)?

A. No. This would not be considered an allowable PC task.

10. Is the aide allowed to reside within the same household as the participant?

A. Yes. In reviewing the Code of State Regulation there is nothing which prohibits the aide from residing in the same household as the participant. However, the aide must meet the requirement of an in-home personal care worker. Per 13 CSR 70-91.010 an in-home personal care worker "may not be a family member of the recipient for whom personal care is to be provided. A family member is defined as a parent; sibling; child by blood, adoption or marriage (stepchild); spouse; grandparent or grandchild."

11. Is the act of transferring a participant included within other tasks or should all transfer time be authorized under mobility/transfers.

A. If a task such as bathing or toileting includes the need for a transfer, the transfer time should stay with that task. If transfer is done outside of another task such as moving from a bed to wheelchair, that time should be authorized under mobility/transfers.

12. If a participant is a safety concern (e.g. fall risk, developmental disability and at risk for burning self, etc) and needs stand by assistance during a bath to ensure safety, can time be authorized under bathing even if hands-on assistance is only available in case of safety issue arising?

A. Time may be given for participants that are at risk for safety concern while bathing. When possible, DSDS staff or designee should help the participant obtain resources such as a grab bar or shower chair to help decrease/eliminate the need for this time. If a participant can safely do the task with adaptations (grab bar, shower chair) the time should not be given or should be removed from the care plan once the adaptations are put into place.

13. Incontinence can lead to a need of variety of tasks such as laundry, bed linen changes, dressing, toileting, and bathing. How should DSDS staff or designee decide which tasks to authorize in these instances?

HCBS Policy Clarification Questions

A. This type of scenario can vary greatly. DSDS staff or designee should choose a person-centered approach and provide case note documentation for the increased need for incontinence assistance within all associated tasks.

14. If participant is requesting application of non-prescription ointment/cream, what task would this be authorized as on the care plan?

A. This would be included with self-administration of meds.

15. If a participant has an oxygen concentrator, can the aide clean the tubing and add water to the concentrator, as well as clean the filter?

A. This is considered Basic Personal Care (PC) under self-administration of medications; the aide is allowed to assist with cleaning the tubing, filter, and adding water to the machine.

HCBS Policy Clarification Questions

Respite Care

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

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

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

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

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

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

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

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

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

5. Why are participants with Blind Pension ME code 02 not eligible for a waiver, but participants with ME code 03 Supplemental Aide to the Blind are eligible?

A. Eligibility is based on funding and income. ME code 03 Supplemental Aide to the Blind meets the federally funded Medicaid requirement for HCBS waivers. ME code 02 Blind Pension does not, as it is a state-funded only code. Participants with income above the threshold for ME 03 Supplemental Aide to the Blind will receive ME code 02 Blind Pension, which makes them ineligible for an HCBS waiver service.

HCBS Policy Clarification Questions

Shared Living Spaces

1. What is a shared living space?

A. 19 CSR 15-8.100 defines unmet needs as routine tasks and activities of daily living which cannot be reasonably met by members of the consumer's household or other current support systems without causing undue hardship. A shared living space is considered a space requiring tasks such as cleaning that could reasonably be met by another able-bodied member of the consumer's household who also uses that living space. HCBS are person-centered; therefore, each participant's living arrangements and unmet needs shall be considered to develop their care plan.

2. What household dynamics should be taken into consideration when building a care plan for participants living with others? (Same guidance applies for Agency Model and CDS services.)

A. Living as Roommates

- If the participant lives with a roommate, in which resources and responsibility are not shared with each other, time could be authorized for tasks such as shopping/errands, meals, and laundry. Cleaning of shared areas, (e.g., bathroom/living area) should only be authorized in special circumstances such as other household member is also physically unable to clean, or additional cleaning time is needed in areas due to the participant having incontinence issues or another health-related need. The need for cleaning of shared household space despite the fact other adults are in the home should be thoroughly documented in case notes.

Special/Alternative Diet for Household Members

- If meals are not shared due to a special or alternative diet (e.g. physician ordered diet, vegan, vegetarian, etc.) being followed by either household member, then the participant can be authorized for separate mealtime. Time cannot be authorized separately because the participant prefers to eat at different times than others in the household or prefers different food. The authorization for mealtime, despite the fact of living with other adults, should be thoroughly documented in case notes.

Both Household Members Receive HCBS Services

- Personal Care time should be authorized as needed for each participant.
- If there are no special circumstances that would prevent them from sharing meals or needing extra cleaning time, time for cleaning shared spaces and meal prep should be split between the household members. This will ensure both participants continue receiving assistance with those tasks if the other member were to enter a facility, move out or pass away.

Meal Prep Authorization When Living with "Able Bodied" Individuals

- If the other adults living in the home are gone during the day due to work or other reasons, time can be authorized for meals during that time frame. Additionally, if the participant needs

assistance with cutting up food or bringing food to them, time can be authorized despite being in a shared household.

Other Household Member is Physically Disabled

- If the other person in the home is disabled, then full time can be authorized for meal prep and cleaning. The participant should not have to go without needed assistance if they are living with an individual who is not able to maintain the living environment or meet the participant's PC needs. This should be thoroughly documented in case notes.

Teenagers and Shared Living Spaces

- Minor children (under 18) should not be considered when developing the care plan regarding shared living spaces. However, the authorized tasks should only be for the needs of the participant. For example, time would be authorized to clean the living room in its entirety; however, time would only be authorized to wash dishes for the participant, not other members of the household.

HCBS Policy Clarification Questions

Structured Family Caregiving Waiver (SFCW)

1. The Structured Family Caregiving Waiver policy states a family member can be the primary and substitute caregiver. Which family members are allowed to be the caregiver?

A. Anyone including guardians, spouses and family members are allowed to be the primary and substitute caregivers.

2. Can the SFCW primary caregiver have outside employment?

A. Yes, the caregiver may have other employment, including work outside the home, if appropriate support systems are in place and the participant's health and safety are not affected. The key is that the participant's needs are met—not that the caregiver is physically at their side all day long.

HCBS Policy Clarification Questions

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

***CDS may complete all Basic Personal Care and Advanced Personal Care tasks**

HCBS Policy Clarification Questions

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

***CDS may complete all Basic Personal Care and Advanced Personal Care tasks**

HCBS Policy Clarification Questions

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

***CDS may complete all Basic Personal Care and Advanced Personal Care tasks**