State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
PERSONAL CARE OPTION (PCO) SERVICES

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED REGULATIONS

V. BACKGROUND SUMMARY

The Human Serviced Department (HSD), Medical Assistance Division (MAD or Medicaid), is proposing to repeal and replace regulations at 8.315.4 NMAC, *Personal Care Option Services.* The following is a summary of the most significant proposed changes:

- Strengthening language throughout to clarify that duplicative PCO services are not allowed for individuals receiving the same or similar services by other sources including natural supports. PCO services are supplemental to other sources including natural supports;
- Clarifying cognitive assistance as a service within each appropriate Activity of Daily Living (ADL) and Instrumental Activity of Daily Living (IADL) service;
- Requiring a legal representative for those in self direction that cannot make their own choices or communicate their responses;
- Restructuring consumer delegated and directed regulations so it is not as repetitive and so that it adequately describes the roles and responsibilities of the PCO agency, caregivers and members;
- Replacing the MAD 075 medical assessment form with the Income Support Division (ISD) 379 medical assessment form;
- Clarifying the eligible population;
- Clarifying covered and non-covered PCO services;
- Clarifying temporary authorizations for PCO services;

- Introducing a Personal Care Options Service Guide for use in recording observations and responses regarding an individual's functional level and independence to perform ADLs and IADLs. The guide provides an impairment rating system for identifying PCO services and service time ranges;
- Strengthening and/or clarifying the role of managed care wherever possible rather than older fee-for-service language; and
- Clarifying sanctions and remedies.

VI. REGULATIONS

These proposed regulation changes refer to 8.315.4 NMAC of the MAD Program Manual. This register and the proposed changes are available on the MAD web site at www.hsd.state.nm.us/mad/registers/2010. If you do not have Internet access, a copy of the regulations may be requested by contacting MAD at 827-3156.

VII. EFFECTIVE DATE

The Department proposes to implement these regulations effective December 30, 2010.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed regulations will be held at 10:00 a.m. on Tuesday, November 16, 2010, in the ASD conference room of Plaza San Miguel, 729 St. Michael's Drive, Santa Fe.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Division toll free at 1-888-997-2583 and ask for extension 7-3156. In Santa Fe call 827-3156. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by MAD upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Kathryn Falls, Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5:00 p.m. on November 16, 2010. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons may also address comments via electronic mail to: Magdalena.Romero@state.nm.us.

X. PUBLICATIONS

Publication of these regulations approved by:

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KATHRYN FALLS, SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE SOCIAL SERVICES
CHAPTER 315 OTHER LONG TERM CARE SERVICES
PART 4 PERSONAL CARE OPTION SERVICES

8.315.4.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.315.4.1 NMAC - Rp, 8.315.4.1 NMAC, 9-15-10; Rp, 8.315.4.1 NMAC, 12-30-10]

8.315.4.2 SCOPE: The rule applies to the general public.
[8.315.4.2 NMAC - Rp, 8.315.4.2 NMAC, 12-30-10]

8.315.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.315.4.3 NMAC - Rp, 8.315.4.3 NMAC, 12-30-10]

8.315.4.4 DURATION: Permanent
[8.315.4.4 NMAC - Rp, 8.315.4.4 NMAC, 12-30-10]

8.315.4.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.315.4.5 NMAC - Rp, 8.315.4.5 NMAC, 12-30-10]

8.315.4.6 OBJECTIVE: The objective of this rule is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, non-covered services, utilization review, and provider reimbursement.
[8.315.4.6 NMAC - Rp, 8.315.4.6 NMAC, 12-30-10]

8.315.4.7 DEFINITIONS: [RESERVED]

8.315.4.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[8.315.4.8 NMAC - Rp, 8.315.4.8 NMAC, 12-30-10]

8.315.4.9 PERSONAL CARE OPTION SERVICES: Personal care option (PCO) services have been established by the New Mexico human services department (HSD), medical assistance division (MAD or medicaid) to assist individuals 21 years of age or older who are eligible for full medicaid coverage and meet the nursing facility (NF) level of care (LOC) criteria, see, *long term care services utilization review instructions for nursing facilities* which is attached to this part of the NMAC as attachment II. These regulations describe PCO services for consumers who are unable to perform at least two activities of daily living (ADLs) because of disability or functional limitation and need assistance with certain ADLs and instrumental activities of daily living (IADLs) as described in attachment I to this part of the NMAC.

A. A third-party assessor (TPA) determines medical LOC for PCO eligibility upon initial application and at least annually thereafter. Medicaid-eligible individuals may contact the TPA or the managed care organization (MCO) for coordinated long-term care services (CoLTS) (if applicable) to apply for PCO services.

B. The goals of PCO services are to avoid institutionalization and to maintain the individual's functional level and independence. PCO services are not provided 24-hours a day.

C. PCO is a medicaid service, not a medicaid category of assistance, and services under this option are delivered pursuant to an individual plan of care (IPoC). PCO services include a range of ADL and IADL services to consumers who are unable to perform at least two ADLs because of a disability or a functional limitation(s). Consumers will be assessed for services at least annually, or more frequently, as appropriate. PCO services will not include those services for tasks the individual is already receiving from other sources including tasks provided by natural supports. Natural supports are friends, family, and the community (through individuals, clubs, organizations) that provide supports and services to the consumer. The assessment for services is performed by the TPA for fee-for-service (FFS) or the MCO for CoLTS. The PCO service assessment will determine the amount and type of services needed to supplement the services a consumer is already receiving including those

services provided by natural supports. PCO services must be closely aligned with the individual's impairment rating as indicated in the Personal Care Options Service Guide, MAD 055, which is attached to this part of the NMAC as attachment I.
[8.315.4.9 NMAC - Rp, 8.315.4.9 NMAC, 12-30-10]

8.315.4.10 SERVICE DELIVERY MODELS:

A. Individuals eligible for PCO services have the option of choosing the consumer-delegated or the consumer-directed personal care model. Under both models, the consumer may select a family member (except a spouse), friend, neighbor, or other individual as the attendant. Under the consumer-delegated model, the consumer chooses the PCO agency to perform all employer-related tasks and the agency is responsible for ensuring all service delivery to the consumer. The consumer-directed model allows the consumer to oversee his/her own service care delivery, and requires the consumer to work with a PCO agency that acts as a fiscal intermediary agency to process all financial paperwork to medicaid for FFS or the MCO for consumers enrolled in CoLTS. The TPA for FFS or MCO for CoLTS, or other medicaid designee is responsible for explaining both models to each individual initially and annually thereafter.

B. Consumers who are unable to make a decision regarding the service delivery model or are unable to communicate decisions must have a legal representative to select and participate in the consumer-directed model. If a consumer or the consumer's legal representative chooses consumer-directed personal care, the consumer or the consumer's legal representative retains responsibility for performing certain employer-related tasks. Alternatively, PCO services consumers may select an agency to provide services and perform employer related tasks, known as consumer-delegated personal care. The selected agency must be certified by medicaid or medicaid's designee to perform these tasks.

C. Regardless of which service delivery model is selected by the consumer or the consumer's legal representative, the consumer may hire family members (excluding spouses); however, a family member shall not be reimbursed for a service that he/she would have otherwise provided. A personal care attendant that resides with the consumer, regardless of any family relation, may not be paid to deliver household services, support services, or meal preparation.
[8.315.4.10 NMAC - Rp, 8.315.4.10 NMAC, 12-30-10]

8.315.4.11 CONSUMER'S RESPONSIBILITIES: Consumers receiving PCO services have certain responsibilities depending on the service delivery model they choose.

A. The consumer's or consumer's legal representative's responsibilities under the **consumer-delegated model** include:

(1) verifying that services have been rendered by signing accurate time sheets/logs being submitted to the PCO agency for payroll;

(2) taking the medical assessment form (ISD 379) once a year to his/her physician (a physician's assistant, nurse practitioner or clinical nurse specialist may also sign the ISD 379 in the place of a physician for PCO services only) for completion and submitting the completed form to the TPA and the MCO for CoLTS, if applicable for review; this must be done as required prior to his/her LOC expiring to ensure that there will be no break in services; a consumer who does not submit a timely ISD 379 to the TPA, the MCO for CoLTS to forward to the TPA, as applicable, may experience a break in services; in addition, the consumer must allow the TPA and the MCO for CoLTS, as applicable, to complete assessment visits and other contacts necessary to avoid a break in services;

(3) participating in the development and review of the IPoC;

(4) maintain proof of current vehicle insurance (as mandated by the laws of the state of New Mexico) if the attendant will transport the consumer in the consumer's vehicle for support services that have been allocated to the consumer; and

(5) complying with all medicaid rules, regulations, and PCO service requirements; failure to comply could result in discontinuation of PCO services.

B. The consumer's or the consumer's legal representative's responsibilities under the **consumer-directed model** include:

(1) interviewing, hiring, training, terminating and scheduling personal care attendants; this includes, but is not limited to:

(a) verifying that the attendant possesses a current and valid driver's license if there are any driving-related activities listed on the IPoC; a copy of the current driver's license must be maintained in the attendant's personnel file at all times; if no driving-related activities are listed on the IPoC, a copy of a valid state ID is kept in the attendant's personnel file at all times;

(b) verifying that the attendant has proof of current liability vehicle insurance if the consumer is to be transported in the attendant's vehicle at any time; a copy of the current proof of insurance must be maintained in the attendant's personnel file at all times; and

(c) identifying training needs; this includes training his/her own attendant(s) or arranging for training for the attendant(s);

(2) developing a list of attendants who can be contacted when an unforeseen event occurs that prevents the consumer's regularly scheduled attendant from providing services; making arrangements with attendants to ensure coverage and notifying the agency when arrangements are changed;

(3) verifying that services have been rendered by completing, dating, signing and submitting documentation to the agency for payroll; a consumer or his/her legal representative is responsible for ensuring the submission of accurate timesheets/logs; payment shall not be issued without appropriate documentation;

(4) notifying the agency, within one working day, of the date of hire or the date of termination of his/her attendant and ensure that all relevant employment paperwork and other applicable paperwork is completed and submitted; this may include, but is not limited to: employment application, verification from the employee abuse registry, criminal history screening, doctor's release to work (when applicable), photo identification, proof of eligibility to work in the United States (when applicable), copy of driver's license and proof of insurance (as appropriate);

(5) notifying and submitting a report of an incident (as described in Paragraph (14), Subsection B of 8.315.4.12 NMAC) to the PCO agency within two hours of such incident, so that the PCO agency can submit an incident report on behalf of the consumer; the consumer or his/her legal representative is responsible for completing the incident report;

(6) ensuring that the individual selected for hire has submitted to a request for a nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq. of the Caregivers Criminal History Screening Act, within 20-calendar days of the individual beginning employment; the consumer must work with the selected agency to complete all paperwork required for submitting the nationwide caregiver criminal history screening; the consumer may conditionally (temporarily) employ the individual contingent upon the receipt of written notice that the individual has submitted to a nationwide caregiver criminal history screening; a consumer may not continue employing an attendant who does not successfully pass a nationwide criminal history screening;

(7) obtaining from the attendant a signed agreement, in which the attendant agrees that he/she will not provide PCO services while under the influence of drugs or alcohol and, therefore, acknowledges that if he/she is under the influence of drugs or alcohol while providing PCO services he/she will be immediately terminated and a copy of the signed agreement must be given to the PCO agency;

(8) ensuring that if the attendant is the consumer's legal representative and is the individual selected for hire, prior approval has been obtained from medicaid or its designee; any PCO services provided by the consumer's legal representative *MUST* be justified, in writing, by the PCO agency and consumer and submitted for approval to medicaid or its designee prior to employment; the justification must demonstrate the lack of other qualified attendants in the applicable area and indicate a plan how timesheets will be verified to ensure services were provided; documentation of written approval by medicaid or its designee must be maintained in the consumer's file; the consumer is responsible for immediately informing the agency if the consumer has appointed or obtained a legal representative any time during the plan year;

(9) sign an agreement accepting responsibility for all aspects of care and training including mandatory training in CPR and first aid for all attendants, competency testing, TB testing, hepatitis B immunizations and supervisory visits or waiving the provision of such training and accepting the consequences of such a waiver;

(10) verifying initially prior to employment, and annually thereafter, that attendants are not on the employee abuse registry by researching the Consolidated Online Registry (COR) pursuant to 8.11.6 NMAC and in accordance with the Employee Abuse Registry Act, NMSA, Section 27-7A-1 et seq.;

(11) taking the medical assessment form (ISD 379) or successor document once a year to his/her physician (physician's assistant, nurse practitioner or clinical nurse specialist) for completion and submitting the completed form to the TPA or MCO for CoLTS, as applicable, for review; this must be done at least 60 days prior to his/her LOC expiring to ensure that there will be no break in services; a consumer who does not submit a timely ISD 379 may experience a break in service;

(12) participating in the development and review of the IPoC;

(13) maintain proof of current vehicle insurance (as mandated by the laws of the state of New Mexico) if the attendant will transport the consumer in the consumer's vehicle for support services that have been allocated to the consumer;

(14) a consumer that authorizes services when he/she does not have a currently approved LOC or IPoC is liable for payment of those services, which are not eligible for medicaid reimbursement; and

(13) complying with all medicaid rules, regulations, and PCO service requirements; failure to comply could result in discontinuation of PCO services.

C. Consumers may have a personal representative assist him/her giving instruction to the personal care attendant or provide information to the TPA or MCO during assessments of the consumer's natural supports and service needs. A personal representative is not the same as a legal representative (i.e., power of attorney, guardian ad litem, guardian), but may be the same person, as appropriate. A personal care representative must have the following qualifications: be at least 18 years of age, have a personal relationship with the consumer and understand the consumer's natural supports and service support needs, and know the consumer's daily schedule and routine (to include medications, medical and functional status, likes and dislikes, strengths and weaknesses). A personal representative does not make decisions for the consumer unless he/she is also a legal representative, but may assist the consumer in communicating, as appropriate. A personal representative may not be a personal care attendant. A person's status as a personal representative must be properly documented with the PCO agency.
[8.315.4.11 NMAC - Rp, 8.315.4.11 NMAC, 12-30-10]

8.315.4.12 ELIGIBLE PCO AGENCIES: PCO agencies electing to participate in providing PCO services must obtain certification and have various responsibilities for complying with the requirements for provision of PCO services.

A. **PCO agency certification:** A PCO agency providing either the consumer-directed, the consumer-delegated or both models, must adhere to the requirements of this section. PCO agencies must be certified by medicaid or its designee. An agency listing, by county, is maintained by medicaid or its designee. All certified PCO agencies are required to select a county in which to establish and maintain an official office for conducting of business with published phone number and hours of operation; the PCO agency must provide services in all areas of the county in which the main office is located. The PCO agency may elect to serve any county within 100 miles of the main office. The PCO agency may elect to establish branch office(s) within 100 miles of the main office. The PCO agency must provide PCO services to all areas of any county(ies) selected to provide services. To be certified by medicaid or its designee, agencies must meet the following conditions and submit a packet (contents of paragraphs one through six described below) for approval to medicaid's fiscal agent or its designee containing the following:

(1) a completed medicaid provider participation application (MAD 335);

(2) copies of successfully passed nationwide caregivers criminal history screenings on employees who meet the definition of "caregiver" and "care provider" pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq., of the Caregivers Criminal History Screening Act;

(3) a copy of a current and valid business license or documentation of non-profit status; if certified, a copy of the business license or documentation of non-profit status must be kept current and submitted annually;

(4) proof of liability and workers' compensation insurance; if certified, proof of liability and workers' compensation insurance must be submitted annually;

(5) a copy of written policies and procedures that address:

(a) medicaid's PCO provider rules and regulations;

(b) personnel policies; and

(c) office requirements that include but are not limited to:

(i) contact information, mailing address, physical location if different from mailing address, and hours of operation for the main office and branch offices if any; selected counties for the area(s) of service;

(ii) meeting all Americans with Disabilities Act (ADA) requirements; and

(iii) if PCO agencies have branch offices, the branch office must have a qualified on-site administrator to handle day-to-day operations who receives direction and supervision from the main/central office;

(d) quality improvement to ensure adequate and effective operation, including documentation of quarterly activity that addresses, but is not limited to:

(i) service delivery;

(ii) operational activities;

(iii) quality improvement action plan; and

(iv) documentation of quality improvement activities;

(e) agency operations to furnish services either as a consumer-directed or as a consumer-delegated, or both;

(6) a copy of a current and valid home health license, issued by the department of health, division of health improvement, licensing and certification (pursuant to 7.28.2 NMAC) may be submitted in lieu of requirements (3) and (5 (b) and (d)) above; if certified, a copy of a current and valid home health license must be submitted annually along with proof of liability and workers' compensation insurance;

(7) if the agency requests approval to provide the consumer-delegated model of service, a copy of the agency's written competency test for attendants approved by medicaid or its designee; an agency may select to purchase a competency test or it may develop its own test; the test must address at least the following:

(a) communication skills;
(b) patient/client rights, including respect for cultural diversity;
(c) recording of information for patient/client records;
(d) nutrition and meal preparation;
(e) housekeeping skills;
(f) care of the ill and disabled, including the special needs populations;
(g) emergency response (including CPR and first aid);
(h) universal precautions and basic infection control;
(i) home safety including oxygen and fire safety;
(j) incident management and reporting; and
(k) confidentiality

(8) after the packet is received, reviewed, and approved in writing by medicaid or its designee, the agency will be contacted to complete the rest of the certification process; this will require the agency to:

(a) attend a mandatory medicaid or its designee's provider training session prior to the delivery of PCO services; and

(b) possess a letter from medicaid or its designee changing provider status from "pending" to "active";

(9) an agency will not be certified as a personal care agency if:

(a) it is owned in full or in part by a professional authorized to complete the medical assessment form (ISD 379) or other similar assessment tool subsequently approved by medicaid under PCO or the agency would have any other actual or potential conflict of interest.; or

(b) the agency is authorized to carry out PCO TPA responsibilities, such as in-home assessments, or the agency would have any other actual or potential conflict of interest; and

(c) a conflict of interest is presumed between people who are related within the third degree of blood or consanguinity or when there is a financial relationship between:

(i) persons who are related within the third degree of consanguinity (by blood) or affinity (by marriage) including a person's spouse, children, parents (first degree by blood); siblings, half-siblings, grandchildren or grandparents (second degree by blood and uncles, aunts, nephews, nieces, great grandparents, and great grandchildren (third degree by blood); stepmother, stepfather, mother-in-law, father-in-law (first degree by marriage); stepbrother, stepsister, brothers-in-law, sisters-in-law, step grandchildren, grandparents (second degree by marriage); step uncles, step aunts, step nephews, step nieces, step great grandparents, step great grandchildren (third degree by marriage);

(ii) persons or entities with an ongoing financial relationship with each other including a personal care provider whose principals have a financial interest in an entity or financial relationship with a person who is authorized to complete an ISD 379 or other similar assessment tool or authorized to carry out any of the TPPA's responsibilities; a financial relationship is presumed between spouses.

B. **Approved PCO agency responsibilities:** A personal care agency electing to provide PCO services under either the consumer-directed model or the consumer-delegated model, or both, is responsible for:

(1) furnishing services to medicaid consumers that comply with all specified medicaid participation requirements outlined in 8.302.1 NMAC, *General Provider Policies*;

(2) verifying every month that all consumers are eligible for full medicaid coverage and PCO services prior to furnishing services pursuant to Subsection A of 8.302.1.11 NMAC, *provider responsibilities and requirements*; PCO agencies must document the date and method of eligibility verification; possession of a medicaid card does not guarantee a consumer's financial eligibility because the card itself does not include financial eligibility, dates or other limitations on the consumer's financial eligibility; PCO agencies must notify consumers who are not financially eligible that he/she cannot authorize employment for his/her attendant(s) until financial eligibility is resumed; PCO agencies and consumers cannot bill medicaid or its designee for PCO services rendered to the consumer if he/she is not eligible for PCO services;

(3) maintaining appropriate recordkeeping of services provided and fiscal accountability as required by the PPA;

(4) maintaining records, as required by the PPA and as outlined in 8.302.1 NMAC, *General Provider Policies*, that are sufficient to fully disclose the extent and nature of the services furnished to the consumers;

(5) passing random and targeted audits, conducted by medicaid or its designee, that ensure agencies are billing appropriately for services rendered; medicaid or its designee will seek recoupment of funds from agencies when audits show inappropriate billing or inappropriate documentation for services;

(6) providing either the consumer-directed or the consumer-delegated models, or both models;

(7) furnishing their consumers, upon request, with information regarding each model; if the consumer chooses a model that an agency does not offer, the agency must refer the consumer to medicaid or medicaid's designee for a list of agencies that offer that model; the TPA for FFS or the MCO for CoLTS is responsible for explaining each model in detail to consumers on an annual basis;

(8) ensuring that each consumer receiving PCO services has a current, approved IPoC on file;

(9) performing the necessary nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq. of the Caregivers Criminal History Screening Act, on all potential personal care attendants; nationwide caregiver criminal history screenings must be performed by an agency certified to conduct such checks; the agency, along with the consumer, as applicable ensures the paperwork is submitted within the first 20-calendar days of hire; consumers under the consumer-directed model or agencies under the consumer-delegated model may conditionally (temporarily) employ an attendant until such check has been returned from the certified agency; if the attendant does not successfully pass the nationwide caregiver criminal history screening, the agency under consumer-delegated or the consumer under consumer-directed may not continue to employ the attendant;

(10) producing reports or documentation as required by medicaid or its designee;

(11) verifying that consumers will not be receiving services through the following programs while they are receiving PCO services: medicaid home and community-based services (HCBS) waivers with the exception of the CoLTS (c) HCBS waiver, also known as the disabled and elderly (D&E) HCBS waiver, medicaid certified NF, intermediate care facility/mentally retarded (ICF/MR), program of all-inclusive care for the elderly (PACE), or adult protective services (APS) attendant care program; an individual residing in a NF or ICF/MR or receiving a non-qualifying HCBS waiver is eligible to apply for PCO services; all individuals must meet the medicaid and LOC eligibility requirements to receive PCO services; the TPA, medicaid, or its designee must conduct an assessment or evaluation to determine if the transfer is appropriate and if PCO services would be able to meet the needs of that individual;

(12) processing all claims for PCO services in accordance with the billing specifications from medicaid or the MCO for CoLTS, as appropriate; payment shall not be issued without appropriate documentation;

(13) making a referral to an appropriate social service, legal, or state agency, or the MCO for CoLTS for assistance, if the agency questions whether the consumer is able to direct his/her own care or is non-compliant with medicaid rules and regulations;

(14) immediately reporting abuse, neglect or exploitation pursuant to NMSA 1978, Section 27-7-30 and in accordance with the Adult Protective Services Act, by fax, within 24 hours of the incident being reported to the agency; reportable incidents may include but are not limited to abuse, neglect and exploitation as defined below:

(a) abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish to a consumer;

(b) neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness to a consumer;

(c) exploitation is defined as the deliberate misplacement or wrongful, temporary or permanent use of a consumer's belongings or money without the voluntary and informed consent of the consumer;

(15) submitting written incident reports to medicaid or its designee, and the MCO for CoLTs consumers, on behalf of the consumer, within 24 hours of the incident being reported to the PCO agency; the PCO agency must provide the consumer with an appropriate form for completion; reportable incidents may include, but are not limited to:

(a) death of the consumer:

(i) unexpected death is defined as any death of an individual caused by an accident, or an unknown or unanticipated cause;

(ii) natural/expected death is defined as any death of an individual caused by a long-term illness, a diagnosed chronic medical condition, or other natural/expected conditions resulting in death;

(b) other reportable incidents:

(i) environmental hazard is defined as an unsafe condition that creates an immediate threat to life or health of a consumer;

(ii) law enforcement intervention is defined as the arrest or detention of a person by a law enforcement agency, involvement of law enforcement in an incident or event, or placement of a person in a correctional facility;

(iii) emergency services refers to admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care that is not anticipated for this consumer and that would not routinely be provided by a primary care provider;

(iv) any reports made to APS;

(16) informing the consumer and his/her attendant of the responsibilities of the agency;

(17) develop an IPoC based each assessment, services authorization, task list, and consideration of natural supports provided by the TPA for FFS or MCO for CoLTS;

(18) provide an informed consent form to consumers if the agency chooses not to provide transportation services as part of support services;

(19) identifying a consumer with an improved or declining health condition or whose needs have changed (i.e. more or less natural supports) and believe the consumer is in need of more or fewer services should send written notification to the TPA for an LOC determination and the TPA for FFS or MCO for CoLTS for additional assessment of need of services;

(20) except for the CoLTS (c) HCBS waiver, agencies who are providing PCO services to a consumer who becomes eligible for a non-CoLTS (c) HCBS waiver must coordinate with the consumer’s service coordinator to ensure that the consumer does not experience a break in service or that services do not overlap; coordination must include the effective date PCO services are to stop and non-CoLTS (c) HCBS waiver services are to begin;

(21) maintaining documentation in the consumer's file regarding legal and personal representatives, as applicable; and

(22) cooperating with the TPA or MCO in locating and assisting the consumer with submitting the necessary paperwork for an LOC determination;

(23) **For agencies providing PCO services under the consumer-directed model**, the responsibilities include:

(a) obtaining a federal employer identification form from the internal revenue service (IRS) for each consumer;

(b) completing an "appointment of agent" form (IRS form 2678) and submitting to the IRS;

(c) obtaining an approval letter from the IRS to be the consumer's agent and maintaining a copy of the letter in the consumer's file;

(d) obtaining from the consumer or his/her legal representative a signed agreement with the attendant in which the attendant agrees that he/she will not provide PCO services while under the influence of drugs or alcohol and acknowledges that if he/she is under the influence of drugs or alcohol while providing PCO services he/she will be immediately terminated; the agency must maintain a copy of the signed agreement in the attendant’s personnel file, for the consumer;

(e) obtaining a signed agreement from each consumer accepting responsibility for all aspects of care and training including mandatory training in CPR and first aid for all attendants, competency testing, TB testing, hepatitis B immunizations or a waiver of providing such training and accepting the consequences thereof, and supervisory visits are not included in the consumer-directed option; a copy of the signed agreement must be maintained in the consumer’s file;

(f) verifying that the consumer has selected the consumer’s legal representative as the attendant, the consumer has obtained prior approval from medicaid or its designee; any personal care services provided by the consumer’s legal representative *MUST* be justified, in writing, by the agency and consumer and submitted for approval to medicaid or its designee prior to employment; the justification must demonstrate the lack of other qualified attendants in the applicable area and indicate how timesheets will be verified to ensure that services were provided; documentation of written approval by medicaid or its designee must be maintained in the consumer’s file; the agency must inform the consumer that if the consumer is appointed or selects a legal representative any time during the plan year, the consumer must notify the agency immediately and the agency must ensure appropriate documentation is maintained in the consumer’s file;

(g) establishing and explaining to the consumer the necessary payroll documentation needed for reimbursement of PCO services, such as time sheets/logs and tax forms;

(h) performing payroll activities for the attendants, such as, but not limited to, state and federal income tax, social security withholdings and make payroll liability payments as required;

(i) arranging for state of New Mexico unemployment coverage and workers' compensation insurance for all attendants;

(j) informing the consumer of available resources for necessary training, if requested by the consumer, in the following areas:

(k) hiring, recruiting, training, and supervision of attendants, including advertising and interviewing techniques;

(l) making a referral to an appropriate social service agency, legal agency(s) or medicaid designee for assistance, if the agency questions whether the consumer is able to direct his/her own care; and

(m) maintaining a consumer file and an attendant personnel file for the consumer for a minimum of six years.

(24) **For agencies providing PCO services under the consumer-delegated model,** the responsibilities include, but are not limited to the following:

(a) employing, terminating and scheduling qualified attendants;

(b) conducting or arranging for training of all attendants for a minimum of 12-hours per year; initial training must be completed within the first three months of employment and must encompass:

(i) an overview of PCO services;

(ii) living with a disability or chronic illness in the community;

(iii) cardiopulmonary resuscitation (CPR) and first aid training; and

(iv) a written competency test with a minimum passing score of 80 percent or better; expenses for all trainings are to be incurred by the agency; other trainings may take place throughout the year as determined by the agency; the agency must maintain in the attendant's file: copies of all trainings, certifications, and specialty training the attendant completed; CPR and first aid certifications must be kept current;

(v) documentation of all training must include at least the following information: name of individual taking training, title of the training, source of instruction, number of hours of instruction, and date instruction was given;

(vi) documentation of competency testing must include at least the following: name of individual being evaluated for competency, date and method used to determine competency, and copy of the attendant's graded and passed competency test in the attendant's personnel file; special accommodations must be made for attendants who are not able to read or write or who speak/read/write a language other than English;

(c) developing and maintaining a procedure to ensure trained and qualified attendants are available as backup for regularly scheduled attendants and emergency situations; complete instructions regarding the consumer's care and a list of attendant duties and responsibilities must be available in each consumer's home;

(d) informing the attendant of the risks of hepatitis B infection per current department of health (DOH) recommendation or the center for disease control and prevention (CDC), as appropriate, and offering hepatitis B immunization at the time of employment at no cost to the attendant; attendants are not considered to be at risk for hepatitis B since only non-medical services are performed; therefore, attendants may refuse the vaccine; documentation of the immunization, prior immunization, or refusal of immunization by the attendant must be in the attendant's personnel file;

(e) obtaining a copy of the attendant's current and valid driver's license or other current and valid photo id, if the consumer is to be transported by the attendant, obtaining a copy of the attendant's current and valid driver's license and current motor vehicle insurance policy; maintaining copies of these documents in the attendant's personnel file at all times;

(f) complying with federal and state regulations and labor laws;

(g) preparing all documentation necessary for payroll;

(h) complying with all specified medicaid participation requirements outlined in 8.302.1 NMAC, *General Provider Policies*;

(i) maintaining records that are sufficient to fully disclose the extent and nature of the services furnished to the consumers as outlined in 8.302.1 NMAC, *General Provider Policies*;

(i) the PCO agency may elect to keep a log/check-off list, in addition to the timesheet, in the consumer's home, describing services provided on a daily basis; if a log/check-off list is maintained, the log must be compared with the weekly timesheet and copies of both the timesheet and the log/check-off list must be kept in the consumer's file;

(ii) the PCO agency may elect to use an electronic system that attendants may use to check in and check out at the end of each period of service delivery. The system must produce records that can be

audited to determine the time of services provided, the type of services provided, and a verification by the consumer or the consumer's legal representative, as appropriate. Failure by a PCO agency to maintain a proper record for audit under this system will subject the PCO agency to recovery by medicaid of any undocumented or insufficiently documented claims;

(j) obtaining from the attendant a signed agreement, in which the attendant agrees that he/she will not provide PCO services while under the influence of drugs or alcohol and acknowledges that if he/she is under the influence of drugs alcohol while providing PCO services he/she will be immediately terminated;

(k) ensuring that if the consumer has elected the consumer's legal representative as his/her attendant, the agency has obtained prior approval from medicaid or its designee; all PCO services provided by the consumer's legal representative *MUST* be justified in writing by the agency and consumer and submitted for approval to medicaid or its designee prior to employment; the justification must demonstrate the lack of other qualified attendants in the applicable area and include a plan for oversight by the agency to assure service delivery; documentation of approval by medicaid or its designee must be maintained in the consumer's file; the agency must inform the consumer that if the consumer is appointed or elects a legal representative any time during the plan year, they must notify the agency immediately;

(l) establishing and explaining to all their consumers and all attendants the necessary documentation needed for reimbursement of PCO services;

(m) performing payroll activities for the attendants;

(n) providing state of New Mexico workers' compensation insurance for all attendants;

(o) conducting face-to-face supervisory visits in the consumer's residence at least once a month (12 per service plan year); each visit must be sufficiently documented in the consumer's file by indicating:

(i) date of visit;

(ii) time visiting to include length of visit;

(iii) name and title of person conducting supervisory visit;

(iv) individuals present during visit;

(v) review of IPoC;

(vi) identification of health and safety issues and quality of care provided by attendant, and

(vii) signature of consumer or consumer's legal representataive;

(p) maintaining an accessible and responsive 24-hour communication system for consumers to use in emergency situations to contact the agency;

(q) following current recommendations of DOH and CDC, as appropriate, for preventing the transmission of tuberculosis (TB) for attendants upon initial employment and as needed; and

(r) verifying initially prior to employment, and annually thereafter, that attendants are not on the employee abuse registry by researching COR pursuant to 8.11.6 NMAC and in accordance with the Employee Abuse Registry Act, NMSA 1978, Section 27-7A-1 et seq.

[8.315.4.12 NMAC - Rp, 8.315.4.12 NMAC, 12-30-10]

8.315.4.13 PERSONAL CARE ATTENDANT RESPONSIBLITIES: Personal care attendants providing PCO services for consumers electing either **consumer-directed or consumer delegated** must comply with the following responsibilities and requirements. They include:

A. being hired by the consumer (consumer-directed model) or the PCO agency (consumer-delegated model);

B. not being the spouse of a consumer pursuant to 42 CFR Section 440.167 and CMS state medicaid manual section 4480-D;

C. providing the consumer (consumer-directed) or the PCO agency (consumer-delegated) with proof of and copies of current/valid driver's license or current/valid photo ID and if the attendant will be transporting the consumer, current/valid driver's license and current motor vehicle insurance policy;

D. being 18 years of age or older;

E. ensuring that if the attendant is the consumer's legal representative and is the selected individual for hire, prior approval has been obtained from medicaid or its designee; any personal care services provided by the consumer's legal representative *MUST* be justified, in writing, by the PCO agency and consumer and submitted for written approval to medicaid or its designee prior to employment; the justification must demonstrate the lack of other qualified attendants in the applicable area and indicate how timesheets will be verified to ensure that services were provided; documentation of approval by medicaid or its designee must be maintained in the consumer's file

and submit appropriate documentation of time worked and services performed ensuring that he/she has signed his/her time sheet/log/check-off list verifying the services provided to the consumer;

F. successfully passing a nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq., of the Caregivers Criminal History Screening Act, performed by an agency certified to conduct such checks; attendants are required to submit to a criminal history screening within the first 20-days of hire; an attendant may be conditionally hired by the agency contingent upon the receipt of written notice from the certified agency of the results of the nationwide criminal history screening; attendants who do not successfully pass a nationwide criminal history screening are not eligible for further PCO service employment;

G. ensuring while employed as an attendant he/she will not be under the influence of drugs or alcohol while performing PCO services; the attendant must complete and sign an agreement with the agency or consumer in which the attendant acknowledges that if he/she is under the influence of drugs or alcohol while providing PCO services he/she will be immediately terminated;

H. may not be the consumer's personal representative, unless he/she is also the legal representative;

I. if the attendant is a member of the consumer's family, he/she may not be paid for services that would have otherwise been provided to the consumer; if the attendant is a member of the consumer's household, he/she may not be paid for household services, support services (shopping and errands), or meal preparation;

J. an attendant may not act as the consumer's legal representative, in matters regarding medical treatment, financial or budgetary decision making, unless the attendant has documentation authorizing the attendant to act in a legal capacity on behalf of the consumer;

K. following current recommendations of DOH and CDC, as appropriate for preventing the transmission of TB, and

L. for **consumer-delegated care only**, completing 12-hours of training yearly; the attendant must obtain certification of CPR and first aid training within the first three months of employment, and the attendant must maintain certification throughout the entire duration of providing PCO services; additional training will be based on the consumer's needs as listed in the IPoC; attendants are not required to be reimbursed for training time and successfully passing a written personal care attendant competency test with 80 percent or better within the first three months of employment for consumer-delegated care;

[8.315.4.13 NMAC - Rp, 8.315.4.13 NMAC, 12-30-10]

8.315.4.14 ELIGIBLE POPULATION: To be eligible for PCO services, consumers must meet all of the following criteria:

A. be a recipient of a full benefit medicaid category of assistance and, except for CoLTS (c) HCBS waiver, not be receiving other medicaid HCBS waiver benefits, medicaid NF, intermediate care facility/mentally retarded (ICF/MR) medicaid, PACE, or APS attendant care program , at the time PCO services are furnished; an individual residing in a NF or ICF/MR medicaid or receiving medicaid under a non-CoLTS (c) HCBS waiver is eligible to apply for PCO services to facilitate NF discharge; all individuals must meet the medicaid eligibility requirements to receive PCO services; the TPA, medicaid or its alternative designee must conduct an assessment or evaluation to determine if the transfer to PCO is appropriate and if the PCO services would be able to meet the needs of that individual;

B. be age 21 or older;

C. be determined to have met NF LOC by the TPA; and

D. comply with all medicaid and PCO regulations and procedures.

[8.315.4.14 NMAC - Rp, 8.315.4.14 NMAC, 12-30-10]

8.315.4.15 COVERAGE CRITERIA: PCO services have been established to assist individuals 21 years of age or older who are eligible for full medicaid benefits and meet the NF LOC criteria, see, *long term care services utilization review instructions for nursing facilities* which is attached to this part of the NMAC as attachment II. PCO services are defined as those tasks necessary to avoid institutionalization and maintain the consumer's functional level and independence. PCO services are for consumers who are unable to perform at least two ADLs because of disability or functional limitation and need assistance with certain ADLs and IADLs as described in Attachment II to this part of the NMAC. PCO services are allocated for a reasonable accommodation of tasks to be performed by a personal care attendant, but do not provide 24-hours per day services. A PCO service assessment determines the amount and type of services needed to supplement the services a consumer is already receiving including those services provided by natural supports. PCO services must be closely aligned with the individual's

impairment rating as indicated in the PCO Service Guide, MAD 055 which is attached to this part of the NMAC as attachment I.

A. PCO services are usually furnished in the consumer's place of residence, except as otherwise indicated, and during the hours specified in the consumer's IPoC. Services may be furnished outside the residence only when appropriate and necessary and when not available through other existing benefits and programs, such as home health or other state plan or long-term care services. If a consumer is receiving hospice care, is a resident in an assisted living facility, shelter home, or room and board facility, the TPA for FFS or the MCO for CoLTS, will perform an assessment and ensure that the PCO services do not duplicate the services that are already being provided. If ADL or IADL services are part of the hospice or assisted living facility, shelter home, or room and board facility, as indicated by the contact or admission agreement signed by the consumer, PCO services cannot duplicate those services. Regulations for assisted living facilities may be found at 7.8.2 NMAC, *Requirements for Adult Residential Care Facilities*.

B. PCO services are not furnished to an individual who is an inpatient or resident of a hospital, NF, ICF/MR, mental health facility, correctional facility, other institutional settings.

C. All consumers, regardless of living arrangements, will be assessed for natural supports. PCO services are not intended to replace natural supports. Service hours will be allocated, as appropriate, to supplement the natural supports available to a consumer. Consumers that reside with other adult household members, that are not receiving PCO services, will be presumed to have household services provided by the other adult residents, whether or not the adult residents are the selected personal care attendant. Personal care attendants that live with the consumer will not be paid to deliver household services, support services (shopping and errands), or meal preparation. If a consumer's living situation changes:

(1) such that there is no longer a shared living space with another consumer, he/she will be re-assessed for services that were allocated between multiple consumers in a shared household; or

(2) such that he/she begins sharing a living space with another consumer(s), all consumers in the new shared living space will be re-assessed to determine the allocation of services shared by all consumers residing in the household; or

(3) such that the consumer begins to reside with or no longer resides with another adult in the household that is not receiving PCO services; the consumer will be assessed for the need of household, support services (shopping and errands) and meal preparation if there are no other adults not receiving PCO services in the home, or conversely, the consumer will no longer receive household, support services (shopping and errands), or meal preparation if another adult not receiving PCO services resides with the consumer.

[8.315.4.15 NMAC - Rp, 8.315.4.15 NMAC, 12-30-10]

8.315.4.16 COVERED SERVICES: PCO services are provided as described in Subsections A through J. Consumers will be assessed both individually and jointly if sharing a living space with another PCO applicant/recipient (Subsection K), in each of the following listed service categories. PCO services will not include those services for tasks the individual does not need or is already receiving from other sources including tasks provided by natural supports. PCO services must be closely aligned with the individual's impairment rating as indicated in the PCO Service Guide, MAD 055 which is attached to this part of the NMAC as attachment I.

A. **Individualized bowel and bladder services:** These services include bowel care, bladder care, perineal care and toileting.

(1) Pursuant to NMSA 1978, Section 61-3-29(J) of the Nursing Practice Act, bowel and bladder care may be provided to a consumer that is medically stable and able to communicate and assess his/her own needs to include:

(a) bowel care - evacuation and ostomy care, changing and cleaning of bags and ostomy site skin care; an individual requiring assistance with bowel care who does not have a statement by his/her physician determining he/she is medically stable and able to communicate his/her bladder care needs is not eligible for PCO services in this category; digital stimulation is not a covered service; and

(b) bladder care - cueing the consumer to empty his/her bladder at timed intervals to prevent incontinence; elimination; catheter care, including the changing and cleaning of the catheter bag; the requirements and limitations from (a) bowel care regarding medically determined stability and ability to communicate apply here; insertion/extraction of a catheter is not a covered service.

(2) Services that do not require the consumer to be medically stable and able to communicate and assess his/her own needs include:

(a) perineal care - cleansing of the perineal area and changing of sanitary napkins; and

(b) toileting – assisting with bedside commode and/or bedpan; cleaning perineal area, changing adult briefs/pads, readjusting clothing; cleaning changing of wet or soiled clothing after incontinence episodes or assisting with adjustment of clothing before and after toileting.

B. **Meal preparation and assistance:** At the direction of the consumer or his/her personal representative, prepare meal(s) including cutting ingredients to be cooked, cooking of meals, and placing/presenting meal in front of consumer to eat, and cutting up food into bite-sized portions for the consumer or assist the consumer pursuant to the IPoC. This includes provision of snacks and fluids and may include cueing and prompting the consumer to prepare meals. This does not include assistance with eating. Services requiring assistance with eating are covered under eating in Subsection G below. Personal care attendants who reside in the same household as the consumer may not be paid for meal preparation.

C. **Support services:** These are services that provide additional assistance to the consumer. Personal care attendants who reside in the household may not be paid for shopping or errands. These services are limited to:

(1) shopping or completing errands for the consumer (with or without the consumer);

(2) transportation of the consumer – transportation shall only be for non-medically necessary events and may include assistance with transfers in/out of vehicles; PCO agencies are not required to provide this service; consumers that need this service and are with a PCO agency that does not provide this service may transfer to a different PCO agency in accordance with 8.315.4.21 NMAC; medically necessary transportation services are not covered as PCO services; and

(3) assistance with feeding and hydrating or cueing consumer to feed and hydrate a personal assistance animal for the consumer is a covered service; a consumer must provide documentation that his/her animal is a personal assistance animal; feeding and hydrating non-assistance animals is not a covered service.

D. **Hygiene/grooming**: The IPoC may include the following tasks to be performed by the attendant or cueing and prompting by the attendant for the consumer to perform the tasks. These services include:

(1) bathing - giving a sponge bath/bed bath/tub bath/shower, including transfer in/out, turning bath/shower water off/on, and setting temperature of bath/shower water; bringing in water from outside or heating water for consumer;

(2) dressing - putting on, fastening, removing clothing, and shoes;

(3) grooming - combing or brushing hair, applying make-up, trimming beard or mustache, braiding hair, shaving under arms, legs or face;

(4) oral care with intact swallowing reflex - brushing teeth, cleaning dentures/partials (includes use of floss, swabs, or mouthwash);

(5) nail care – cleaning, filing to trim, or cuticle care, except for consumers with a medical condition such as venous insufficiency, diabetes, peripheral neuropathy, or consumers that are documented as medically at risk, which then would be considered a skilled task and not a covered PCO service;

(6) applying lotion to intact skin for routine skin care; and

(7) cueing to ensure appropriate bathing, dressing, grooming, oral care, nail care and application of lotion for routine skin care.

E. **Minor maintenance of assistive device(s):** Battery replacement and minor, routine wheelchair and durable medical equipment (DME) maintenance or cleaning is a covered service. A consumer must have an assistive device(s) that requires regular cleaning or maintenance (that is not already provided by the supplier of the assistive device) that the consumer cannot clean and maintain to be eligible to receive services under this category.

F. **Mobility assistance:** Either physical assistance or verbal prompting and cueing provided by the attendant is a covered service. These include assistance with:

(1) ambulation - moving around inside or outside the residence or consumer's living area with or without assistive device(s) such as walkers, canes and wheelchairs;

(2) transferring - moving to/from one location/position to another with or without assistive devices(s) including in and out of vehicles;

(3) toileting - transferring on/off toilet; and

(4) repositioning - turning or moving an individual to another position who is bed bound to prevent skin breakdown.

G. **Eating:** Feeding the consumer or assisting the consumer with eating a prepared meal with a utensil or with specialized utensils is a covered service. Eating is the ability to physically put food into mouth, chew and swallow food safely. The attendant shall assist the consumer as determined by the IPoC. Eating assistance may include cueing a consumer to ensure appropriate nutritional intake or monitor for choking. This does not include preparation of food/meals. Services requiring preparation of food/meals is covered under meal preparation and

assistance in Subsection B, *covered services*. If the consumer has special needs in this area, the attendant should receive specific instruction to meet that need. Gastrostomy feeding and tube feeding are not covered services.

H. **Assisting with self-administered medication:** This service is limited to *prompting and reminding only* for self-administering physician ordered (prescription) medications. The use of over the counter medications does not qualify for this service. The ability to self-administer is defined as the ability to identify and communicate medication name, dosage, frequency and reason for the medication. A consumer who does not meet this definition of ability to self-administer is not eligible for this service. This assistance does not include administration of injections, which is a skilled/nursing task. Splitting or crushing medication or filling of medication boxes is not a covered service. Assistance includes:

(1) getting a glass of water or other liquid as requested by the consumer for the purpose of taking medications;

(2) at the direction of the consumer handing the consumer his/her daily medication box or medication bottle;

(3) at the direction of the consumer, helping a consumer with placement of oxygen tubes for consumers who can communicate to the caregiver the dosage/route of oxygen;

(4) splitting or crushing medication or filling of medication boxes is not a covered service.

I. **Skin care:** The consumer must have a skin disorder documented by a physician, physician assistant, nurse practitioner or a clinical nurse specialist to be eligible to receive skin care services. This service is limited to the attendant's application of over-the counter or prescription skin cream for a diagnosed chronic skin condition that is not related to burns, pressure sores or ulceration of skin. A consumer must meet the definition of "ability to self-administer" defined in Subsection H of this section, to be eligible to receive time for application of a prescription over the counter medication for skin care. Wound care/open sores and debriding/dressing open wounds are not covered services.

J. **Household services:** This service is for performing interior household activities as needed. Such activities are limited to the maintenance of the consumer's personal living area (i.e., kitchen, living room, bedroom, and bathroom). To maintain a clean and safe environment for the consumer, particularly a consumer living alone who may not have adequate support in his/her residence. Personal care attendants who reside in the same household as the consumer may not be paid for this service. Services include:

(1) sweeping, mopping or vacuuming the consumer's carpets, hardwood floors, tile or linoleum;

(2) dusting the consumer's furniture;

(3) changing the consumer's linens;

(4) washing the consumer's laundry;

(5) cleaning the consumer's bathroom (tub or shower area, sink, and toilet);

(6) cleaning the consumer's kitchen and dining area (i.e., washing the consumer's dishes, putting the consumer's dishes away; cleaning counter tops, cleaning the area where the consumer eats, etc.); household services do not include cleaning up after other household members or pets.

K. **Shared households/living space**: Two or more consumers living in the same residence, (including assisted living facilities, shelter homes, and other similar living arrangements), who are receiving PCO services will be assessed both individually and jointly to determine services that are shared. Consumers sharing living space will be assessed as follows for services identified in Subsections B, C and J of 8.315.4.16 NMAC:

(1) individually to determine if the consumer requires unique assistance with the service; and

(2) jointly with other household members to determine shared living space and common needs of the household; services will be allocated based on common needs, not based on individual needs, unless it has been assessed by the TPA for FFS or the MCO for CoLTS, there is an individual need for provision of the service(s); (common needs may include meals that can be prepared for several individuals; shopping/errands that can be completed at the same time; laundry that can be completed for more than one individual at the same time; dusting and vacuuming of shared living spaces), these PCO services are based on the assessment of combined needs in the household without replacing natural and unpaid supports identified during the assessment.

[8.315.4.16 NMAC - Rp, 8.315.4.16 NMAC, 12-30-10]

8.315.4.17 NON-COVERED SERVICES: The following services are not covered as New Mexico medicaid PCO services:

A. services to an inpatient or resident of a hospital, NF, ICF/MR, mental health facility, correctional facility or other institutional setting;

B. services that are already being provided by other sources including natural supports;

C. household services, support services (shopping and errands), or meal preparation for consumers that reside with other adult household members, that are not receiving PCO services;
D. services that must be provided by a person with professional licensure or technical training;
E. services not approved in the consumer's approved IPoC;
F. childcare, pet care or personal care for other household members not receiving PCO services;
G. retroactive services;
H. services provided to a consumer who does not have medicaid eligibility;
I. assistance with finances and budgeting;
J. scheduling of appointments for a consumer;
K. range of motion exercises
L. wound care/open sores and debriding/dressing open wounds
M. filling of medication boxes, cutting/grinding pills, administration of injections, assistance with over-the-counter medication or medication that the consumer cannot self-administer;
N. skilled nail care for consumers with a medical condition such as venous insufficiency, diabetes, peripheral neuropathy, or consumers that are documented as medically at risk;
O. medically necessary transportation;
P. bowel and bladder services that include insertion/extraction of a catheter or digital stimulation; and
Q. gastrostomy feeding and tube feeding.
[8.315.4.17 NMAC - Rp, 8.315.4.17 NMAC, 12-30-10]

8.315.4.18 MEDICAL ELIGIBILITY: To be eligible for PCO services, a consumer must meet the LOC required in a NF.
A. The TPA is responsible for making LOC determinations based on criteria developed by medicaid or medicaid's designee according to national standards. See attachment II to this part titled *long term care services utilization review instructions for nursing facilities*.
(1) **Determine level of care (LOC):** The TPA makes initial LOC determinations and subsequent determinations at least annually thereafter.
(a) An LOC packet is developed and reviewed by the TPA to determine approval for medical eligibility.
(b) The LOC packet must include:
(i) a current (within the last six months) approved medical assessment form (ISD 379) signed by a physician or physician's designee (physician assistant, nurse practitioner or, clinical nurse specialist);
(ii) any other information or medical justification documenting the consumer's functional abilities; and
(iii) an assessment of the consumer's functional needs, performed by the TPA initially through the in-home assessment (MAD 057), or for subsequent approval, subsequent assessments performed by the TPA for FFS or MCO for CoLTS.
(2) The TPA will use the LOC packet to:
(a) make all LOC determinations for all consumers requesting/receiving PCO services;
(b) approve the consumer's LOC for a maximum of one year (12 consecutive months); and a new LOC determination must be made at least annually to ensure the consumer continues to meet medical eligibility criteria for PCO services; each LOC determination must be based on the consumer's current medical condition and need of service(s) and may not be based on prior year LOC determinations; and
(c) contact the consumer for FFS or the MCO within a minimum of 90 days, prior to the expiration of the approved LOC, to begin the re-assessment process for PCO services to prevent a break in service; the TPA for FFS or the MCO for CoLTS shall also provide a notification to the PCO agency, at the same time the consumer is notified, that the LOC is due to expire within 90 days.
B. **Initial in-home assessment:** The TPA must perform an initial in-home assessment (MAD 057) of the consumer's functional needs in the consumer's place of residence. The initial in-home assessment is only done one time by the TPA when the consumer is first evaluated for eligibility for PCO services and not upon annual renewal.
C. The TPA must initially explain both service delivery models, consumer-directed and consumer-delegated to the consumer or his/her legal representative and provide the consumer or his/her legal representative with informational material, allowing the consumer to make the best educated decision possible regarding which model he/she will select. A copy of the consumer's or legal representative's responsibilities in 8.315.4.10 NMAC,

service delivery models, must be provided to each consumer or legal representative. If the consumer is FFS, the TPA must explain both service delivery models and provide a copy of the consumer's responsibilities in 8.315.4.10 NMAC, *service delivery models*, at every annual assessment, based on the service delivery model he/she has selected.

D. A PCO agency that does not agree with the LOC determination made by the TPA or medicaid's designee:

(1) may request a re-review or reconsideration pursuant to medicaid oversight policies, 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953]; and

(2) is responsible for submitting the additional medical justification to the TPA or medicaid's designee and adhering to the timelines as outlined in medicaid oversight policies, 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

E. A consumer that does not agree with the LOC determination made by the TPA may file a grievance with the TPA, request a fair hearing pursuant to 8.352.2 NMAC, *Recipient Hearings,* or request both.

F. Conflict of Interest: The TPA is not authorized to contract with any medicaid approved PCO agency to carry out TPA responsibilities or any person, agency, or entity that would have any other actual or potential conflict of interest as a TPA subcontractor due to its financial or corporate relationship or relationship by blood (consanguinity) or by affinity (by marriage) to the third degree with a PCO personal care provider agency or its principals. A conflict of interest includes the situation in which a principal or a relative of the principal of the prospective TPA contracting entity has a financial interest in a PCO provider agency.

G. Temporary Authorization: If the consumer is determined to meet the medical eligibility criteria to receive PCO services, the TPA automatically gives the consumer a temporary prior-authorization of 10 hours per week for up to 75 days. This temporary prior-authorization is automatic for all consumers that are medically eligible and is not a determination of a consumer's actual need. The consumer's actual need may be higher or lower as determined by the assessment for services performed by the TPA for FFS or the MCO for CoLTS. There is no right to a fair hearing with respect to this temporary prior authorization. The approval for 10 hours is not a guarantee of a minimum amount of services when the consumer is assessed by the TPA for FFS or the MCO for CoLTS for need of services. Temporary prior authorization of services does not guarantee that an individual is eligible for medicaid. PCO agencies must verify monthly all individuals' financial eligibility for medicaid prior to providing services.

H. The TPA shall review the LOC upon a referral from the PCO agency, the consumer the consumer's legal representative, or the MCO for CoLTS regarding an improvement or decline in the consumer's health condition and make a new determination regarding eligibility, as appropriate.

I. The ISD 379 form is used solely to determine the LOC and is not used to determine the need for or the amount of services for a consumer. The MAD 057 is used solely to obtain initial LOC information.
[8.315.4.18 NMAC - Rp, 8.315.4.18 NMAC, 12-30-10]

8.315.4.19 ASSESSMENTS FOR SERVICES: After the consumer is determined to be medically eligible for PCO services, the TPA for FFS or the MCO for CoLTS performs an assessment (personal care options service guide (MAD 055)) of the consumer's natural supports and need of covered services.

A. The assessment performed by the TPA for FFS or the MCO for CoLTS determines the type of covered services needed by the consumer and the amount of time allocated to each type of covered service. PCO services are allocated for a reasonable accommodation of tasks to be performed by a personal care attendant, but do not provide 24-hour per day services. A PCO service assessment determines the amount and type of services needed to supplement the services a consumer is already receiving including those services provided by natural supports. PCO services must be closely aligned with the individual's impairment ratings as indicated in the PCO service guide, MAD 055, which is attached to this part of the NMAC as attachment I. In the rare event that the consumer's functional needs exceed the average allocation of time allotted to perform a particular service task per the recommendation of a medical professional, the TPA for FFS or the MCO for CoLTS may consider authorizing additional time based on the consumer's medical and clinical need(s).

B. The assessment conducted by the TPA for FFS or the MCO for CoLTS shall be based on the current health condition and functional needs of the consumer, to include no duplication of services a consumer is already receiving including those services provided by natural supports, and shall not be based on a prior assessment of the consumer's health condition, functional needs, or existing services.

C. This assessment is sent to the PCO agency by the TPA for FFS or the MCO for CoLTS for the PCO agency to develop the IPoC;

D. The assessment myst be performed by the TPA for FFS or the MCO for CoLTS upon a consumer's initial approval for medical eligibility to receive PCO services and at least annually thereafter. The TPA

for FFS or the MCO for CoLTS must complete an assessment within 75 days from the date of the temporary prior authorization. The assessment may be performed more often than annually, if there is a change in the consumer's condition (either improved or declined), upon the consumer's request, if the full amount of services has not been utilized within the last two months, or upon a referral from a PCO agency regarding the consumer's need for an assessment.

E. The MCO must explain each service delivery model at least annually to consumers enrolled in CoLTS.

F. Consumers enrolled in a CoLTS MCO who disagree with authorized number of hours may also utilize the CoLTS MCO grievance and appeal process, request a fair hearing, or both.

[8.315.4.19 NMAC - Rp, 8.315.4.19 NMAC, 12-30-10]

8.315.4.20 INDIVIDUAL PLAN OF CARE (IPOC): .An IPoC is developed and PCO services are identified, in conjunction with the appropriate assessment for allocating PCO services. The PCO agency develops an IPoC using an authorization, task list provided by the TPA for FFS or the MCO for CoLTS. The finalized IPoC contains approved daily tasks, for a period of seven days at a time, to be performed by the attendant based on the consumer's daily needs. Only those services identified as IADLs (household services, certain support services (shopping and errands) or meal preparation) may be moved to another day within a seven-day IPoC. Any tasks not performed by the attendant for any reason cannot be banked or saved for a later date.

A. The PCO agency must:

(1) develop the IPoC with a specific description of the attendant's responsibilities, including tasks to be performed by the attendant and any special instructions related to maintaining the health and safety of the consumer;

(2) ensure the consumer has participated in the development of the plan and that the IPoC is reviewed and signed by the consumer or the consumer's legal representative; a signature on the IPoC indicates that the consumer or the consumer's legal representative understands what services have been identified and that services will be provided on a weekly basis for a maximum of one year; if a consumer is unable to sign the IPoC and the consumer does not have a legal representative, a thumbprint or personal mark (i.e., an "X") will suffice; if signed by a legal representative, the medicaid designee and the agency must have documentation in the consumer's file verifying the individual is the consumer's legal representative;

(3) maintain an approved IPoC for PCO services for a maximum of one year (12) consecutive months), a new IPoC must be developed at least annually, to ensure the consumer's current needs are being met; a consumer's previous year IPoC is not used or considered in developing a new IPoC and allocating services; a new IPoC must be developed independently at least every year based on the consumer's current medical condition and need of services; the tasks and number of hours in the IPoC must match the authorized tasks and number of hours on the authorization;

(4) provide the consumer and the TPA for FFS or MCO for CoLTS with a copy of their approved IPoC;

(5) obtain an approved task list from the TPA for FFS or MCO for CoLTS; and

(6) obtain a written verification that the consumer or the consumer's legal representative understands that if the consumer does not utilize services (for two months) or the full amount of allocated services (within a two-month period) on the IPoC that these circumstances will be documented in the consumer's file for need of services;

(7) submit a personal care transfer/closure form (MAD 062 or other approved transfer/closure form) to the TPA for FFS or MCO for CoLTS to close out a consumer's IPoC who has passed away or who has not received services for 90-consecutive days.

B. PCO services are to be delivered in the state of New Mexico only. Consumers who require PCO services out of the state, for medically necessary reasons only, must obtain medicaid or medicaid's designee' written approval prior to leaving the state. The following must be submitted for consideration when requesting medically necessary out-of-state services:

(1) a letter from the PCO agency requesting an out-of-state exception and reason for request; the letter must include:

(a) the consumer's name and social security number;

(b) how time sheets/logs/check-off list will be transmitted and payroll checks issued to the attendant;

(c) date the consumer will be leaving the state, including the date of the medical procedure or other medical event, and anticipated date of return; and

(d) where the consumer will be housed after the medical procedure.

(2) a letter or documentation from the physician , surgeon , physician assistant, nurse practitioner, or clinical nurse specialist verifying the date of the medical procedure; and

(3) a copy of the consumer's approved IPoC and a proposed adjusted revision of services to be provided during the time the consumer is out-of-state; support services and household services will not be approved unless justified; if the consumer has been approved for services under self-administered medications, a statement from the physician, physician assistant, nurse practitioner, or cllnical nurse specialist must be included indicating the consumer will continue to have the ability to self-administer for the duration he/she is out-of-state.

[8.315.4.20 NMAC - N, 9-15-10 - Rp, 12-30-10]

8.315.4.21 UTILIZATION REVIEW (UR): All PCO services are subject to utilization review for medical necessity and program compliance. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. All PCO services require prior LOC approval by the TPA; therefore, retroactive services are not authorized. The TPA for FFS or the MCO for CoLTS will perform utilization review for medical necessity. The TPA for FFS or the MCO for CoLTS makes final authorization of PCO services using:

(1) the TPA-approved LOC determination; and

(2) an assessment conducted by the TPA for FFS or the MCO for CoLTS to include the MAD 055.

[8.315.4.21 NMAC - Rp, 8.315.4.21 NMAC, 12-30-10]

8.315.4.22 TRANSFER PROCESS FOR PCO SERVICES: A consumer wishing to transfer services to another medicaid approved PCO agency may request to do so. Transfers within the plan year may be requested by the consumer, but must be approved by medicaid or medicaid's designeeprior to the agency providing PCO services to the consumer. All requests for change of service model (from directed/delegated) must be approved by the TPA for FFS or MCO for CoLTS prior to the receiving agency providing services to the consumer. Transfers may only be initiated by the consumer and may not be requested by the attendant as a result of an employment issue. For consumers enrolled in a CoLTS MCO, the transfer process is determined by medicaid or medicaid's designee and should be initiated by the consumer through the consumer's assigned service coordinator. The consumer must give the reason for the requested transfer.

A. A transfer requested by a consumer may be denied by medicaid or its designee for the following reasons:

(1) the consumer is requesting more hours/services;

(2) the consumer's attendant or family member is requesting the transfer;

(3) the consumer has requested three or more transfers within a six-month period;

(4) the consumer wants his/her legal guardian, spouse or attorney-in-fact to be his/her attendant;

(5) the consumer wants an individual to be his/her attendant who has not successfully passed a nationwide criminal history screening;

(6) the consumer wants an attendant who has been terminated from another agency for fraudulent activities or other misconduct;

(7) the attendant does not want to complete the mandated trainings under the consumer-delegated model;

(8) the consumer does not wish to comply with the medicaid or PCO regulations and procedures; and

(9) there is reason to believe that solicitation has occurred as defined in 8.315.4.22 NMAC, *reimbursement.*

B. The TPA for FFS or MCO for CoLTS will notify the consumer and both the originating agency and the receiving agency of its decision and has 15-working days after receiving the request from the TPA to make a decision. The consumer must work with the TPA for FFS or the MCO for CoLTS to verify his/her request.

C. A consumer who does not agree with the decision may request a fair hearing pursuant to 8.352.2 NMAC, *Recipient Hearings*. The originating agency is responsible for the continuance of PCO services throughout the fair hearing process.

D. The following is the process for submitting a transfer request:

(1) The consumer must inform the TPA for FFS or the MCO for CoLTS of the desire to transfer PCO agencies; the TPA for FFS or the MCO for CoLTS approves or denies requested transfer; if approved, the TPA for FFS or the MCO for CoLTS works with both the agency he/she is currently receiving services from (originating agency) and the agency he/she would like to transfer to (receiving agency) to effectively complete the transfer.

(2) Originating agencies are responsible for continuing service provision until the transfer is complete.

(3) Both the originating and receiving PCO agencies are responsible for following approved transfer procedures (either TPA for FFS or MCO for CoLTS transfer procedures).

(4) After the TPA for FFS or the MCO for CoLTS verifies the consumer's request, the TPA for FFS or the MCO for CoLTS will process the transfer request within 15 working days of receiving the transfer request.

(5) The TPA for FFS or the MCO for CoLTS will issue a new prior authorization number to the receiving agency and make the transfer date effective 10 business days from the date of processing the transfer request with new dates of service and units remaining for the remainder of the IPoC year; the TPA for FFS or the MCO for CoLTS will notify the consumer and the originating and receiving PCO agencies.
[8.315.4.22 NMAC - Rp, 8.315.4.22 NMAC, 12-30-10

8.315.4.23 CONSUMER DISCHARGE: A consumer may be discharged from a PCO agency or may be discharged by the state from receiving any PCO services**.**

A. **PCO agency discharge:** The PCO agency may discharge a consumer for a justifiable reason. Prior to initiating discharge, the PCO agency must send a notice to medicaid or its designee for approval. Once approved by medicaid or its designee, the PCO agency may initiate the discharge process by means of a 30-day written notice to the consumer. The notice must include the consumer's right to request a fair hearing and must include the justifiable reason for the agency's decision to discharge.

(1) A PCO agency may discharge a consumer for a justifiable reason. A justifiable reason for discharge may include:

(a) staffing problems (i.e., excessive request for change in attendants (three or more in a 30-day period);

(b) a consumer demonstrates a pattern of verbal or physical abuse toward attendants or agency personnel, including the use of vulgar or explicit (i.e. sexually) language, sexual harassment, excessive use of force, use of verbal threats or physical threats, demonstrates intimidating behavior; the agency or attendant must have documentation demonstrating the pattern of abuse; the agency may also discharge a consumer if the life of an attendant or agency's staff member is believed to be in immediate danger;

(c) a consumer or family member demonstrates a pattern of uncooperative behavior including not complying with agency or medicaid regulations; not allowing the PCO agency to enter the home to provide services; and continued requests to provide services not approved on the IPoC;

(d) illegal use of narcotics or alcohol abuse; and

(e) fraudulent submission of timesheets; or

(f) living conditions or environment that may pose a health or safety risk or cause harm to the personal care attendant, employee of an agency, TPA, MCO, or other medicaid designee.

(2) The PCO agency must provide the consumer with a current list of medicaid-approved personal care agencies that service the county in which the consumer resides. The PCO agency must assist the consumer in the transfer process and must continue services throughout the transfer process. If the consumer does not select another PCO agency within the 30-day time frame, the current PCO agency must inform the consumer that a break in services will occur until the consumer selects an agency. The discharging agency may not ask the medicaid's designee to terminate the consumer's PCO services.

(3) A consumer has a right to appeal the agency's decision to suspend services as outlined in 8.352.2 NMAC, *Recipient Hearings*. A recipient has 90 days from the date of the suspension notice to request a fair hearing.

B. **Discharge by the State**: Medicaid or its designee reserves the right to exercise its authority to discontinue the consumer's receipt of PCO services due to the consumer's non-compliance with medicaid regulations and PCO service requirements. The consumer's discontinuation of PCO services does not affect his/her medicaid eligibility. The consumer may be discharged for a justifiable reason by means of a 30-day written notice to the consumer. The notice will include duration of discharge, which may be permanent, the consumer's right to request a fair hearing, and the justifiable reason for the decision to discharge. A justifiable reason for discharge may include:

(1) staffing problems (i.e., excessive request for change in attendants three or more in a 30-day period), excessive requests for transfers to other agencies or excessive agency discharges;

(2) a consumer who demonstrates a pattern of verbal or physical abuse toward attendants, agency personnel, or state staff or contractors, including use of vulgar or explicit (i.e. sexually) language, verbal or sexual harassment, excessive use of force, demonstrates intimidating behavior, verbal or physical threats toward attendants, agency personnel, or state staff or contractors;

(3) a consumer or family member who demonstrates a pattern of uncooperative behavior including, not complying with agency, medicaid program requirements or regulations or procedures;
(4) illegal use of narcotics or alcohol abuse; and
(5) fraudulent submission of timesheets; or
(6) unsafe or unhealthy living conditions or environment.
C. PCO agencies, the TPA, and the MCO for CoLTS are all responsible for properly documenting and reporting any incidents involving a consumer that is described in section B one through six above to medicaid or its designee.
[8.315.4.23 NMAC - N, 9-15-10; Rp, 8.315.4 NMAC, 12-30-10]

8.315.4.24 REIMBURSEMENT: A medicaid-approved PCO agency will process billings in accordance with the following:
A. Agencies must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, agencies receive instructions on documentation, billing, and claims processing. Claims must be filed per the billing instructions in the medicaid manual for FFS or instructions from the CoLTS MCO. PCO agencies must use ICD-9-CM diagnosis codes when billing for medicaid services.
B. Reimbursement for PCO services is made at the lesser of the following:
(1) the provider's billed charge;
(2) the medicaid fee schedule for the specific service or procedure; or
(3) the agency's billed charge must be its usual and customary charge for services.
(4) "usual and customary charge" refers to the amount an individual provider charges the general public in the majority of cases for a specific service and level of service.
[8.315.4.22 NMAC - Rp, 8.315.4.20 NMAC, 12-30-10]

8.315.4.25 PCO PROVIDER VOLUNTARY DISENROLLMENT: A medicaid approved PCO agency may choose to discontinue provision of services. Once approved by medicaid or its designee, the PCO agency may initiate the disenrollment process to assist consumers to transfer to another medicaid approved PCO agency. The PCO agency must continue to provide services until consumers have completed the transfer process and the agency has received approval from medicaid or its designee to discontinue services. Prior to disenrollment, the PCO agency must send a notice to medicaid or its designee for approval. The notice must include:
A. consumer notification letter;
B. list of all the medicaid approved personal care agencies serving the county in which the consumer resides; and
C. list of all consumers currently being served by the agency and the MCO in which they are enrolled.
[8.315.4.25 NMAC - N, 12-30-10]

8.315.4.26 SOLICITATION/ADVERTISING: For the purposes of this section, solicitation shall be defined as any communication regarding PCO services from an agency's employees, affiliated providers, agents or contractors to a medicaid recipient who is not a current client that can reasonably be interpreted as intended to influence the recipient to become a client of that entity. Individualized personal solicitation of existing or potential consumers by an agency for their business is strictly prohibited.
A. Prohibited solicitation includes, but is not limited to, the following:
(1) contacting a consumer who is receiving services through another PCO service or any another medicaid program;
(2) contacting a potential consumer to discuss the benefits of its agency, including door to door, telephone and email solicitation;
(3) offering a consumer/attendant a finder fee, kick back, or bribe consisting of anything of value to the consumer to obtain transfers to its agency; see 8.351.2 NMAC, *Sanctions and Remedies;*
(4) directly or indirectly engaging in door-to-door, telephone, or other cold-call marketing activities by the entity's employees, affiliated providers, agents or contractors;
(5) making false promises;
(6) misinterpretation or misrepresentation of medicaid rules, regulations or eligibility;
(7) misrepresenting itself as having affiliation with another entity; and
(8) distributing PCO related marketing materials.

B. Penalties for engaging in solicitation prohibitions: Agencies found to be conducting such activity will be subject to sanctions and remedies as provided in 8.351.2 NMAC and applicable provisions of the PPA.

C. An agency wishing to advertise for PCO service provision, or its agency must first get prior written approval from medicaid or its designee before conducting any such activity. Advertising and community outreach materials means materials that are produced in any medium, on behalf of a PCO agency and can reasonably be interpreted as advertising to potential clients. Only approved advertising materials may be used to conduct any type of community outreach. Advertising or community outreach materials must not misrepresent the agency as having affiliation with another entity or use proprietary titles, such as "medicaid PCO". Any PCO agency conducting any such activity without prior written approval from medicaid or its designee will be subject to sanctions and remedies as provided in 8.351.2 NMAC and applicable provisions of the PPA.
[8.315.4.26 NMAC - Rp, 8.315.4.26 NMAC, 12-30-10

8.315.4.27 SANCTIONS AND REMEDIES: Any agency or contractor that is not compliant with the applicable medicaid regulations is subject to sanctions and remedies as provided in 8.351.2 NMAC.
[8.315.4.27 NMAC - N, 12-30-10]

Personal Care Options Service Guide

8.315.4 NMAC Attachment-I

Name (First, Last)	**Case Number**	**Assessment Type** ☐ Initial ☐ Annual	**Assessment Date**
Caretaker Relative? (non spouse) ☐ Yes ☐ No **Caretaker Lives in Home?** ☐ Yes ☐ No	**Shared Household?** ☐ Yes ☐ No	**Shared With** (Name - First, Last)	**Assessor Name** (First, Last)

Use this guide to record observations and responses regarding an individual's functional level and independence to perform Activities of Daily living (ADLs) and Instrumental Activities of Daily Living (IADLs). Closely align the individual's PCO services and service time ranges with the individual's impairment rating of **1 - Mild, 2 - Severe or 3 – Total**, as indicated in each task. *Exclude services and service time for tasks the individual is already receiving from another source.*

A. INDIVIDUALIZED BOWEL AND BLADDER

Exclude services already receiving from other sources.

Daily Average Minute Range by Impairment Rating

1-Mild 0 – 10	2-Severe 11 - 20	3-Total 21 - 40
☐ Prepare toileting supplies ☐ Help with clothing during toileting ☐ Occasional help with cleaning self ☐ Occasional help with catheter or colostomy care ☐ Standby help ☐ Remind/Monitor	☐ Help on/off bedpan ☐ Help with urinal ☐ Help with toileting hygiene ☐ Help with feminine hygiene needs ☐ Change diapers ☐ Change external catheter ☐ Empty catheter bag ☐ Change colostomy bag ☐ Remind/Monitor	☐ Total help with individualized bowel and bladder

B. SUPPORT SERVICES

Exclude services already receiving from other sources. Include travel time.

Daily Average Minute Range by Impairment Rating

1-Mild 10 - 30	2-Severe 35 - 90	3-Total 35 - 90
☐ Make shopping list ☐ Pick up extra items ☐ Feed/water service animals ☐ Remind/Monitor	☐ Assist consumer with shopping for all items ☐ Pick up medications ☐ Put items away ☐ Feed/water for service animals ☐ Remind/Monitor	☐ Total help with shopping and feed/water for service animals

C. MEAL PREPARATION AND ASSISTANCE

Exclude services already receiving from other sources. For a shared household, using paid caregivers, allow up to 30 minutes/day/member. Allow up to 60 minutes/day for meals that cannot be prepared together because of a medical or safety reasons.

Daily Average Minute Range by Impairment Rating

1-Mild 0 - 30	2-Severe 31 - 45	3-Total 46 - 60
☐ Meal planning ☐ Help prepare meals ☐ Warm, cut, serve prepared food ☐ Remind/Monitor	☐ Cook full meal(s) ☐ Grind/puree food ☐ Remind/Monitor Indicate meal(s) to be cooked: ☐ Breakfast ☐ Lunch ☐ Supper	☐ Total help with meal preparation

D. HYGIENE/GROOMING

Exclude services already receiving from other sources. **Add 30 minutes per day for hauling and heating water.**

Daily Average Minute Range by Impairment Rating

Bath – 1-Mild 0 – 15	2-Severe 16 – 30	3-Total 31 - 60
Dress - 1-Mild 0 – 15	2-Severe 16 - 20	3-Total 21 - 30
Groom – 1-Mild 0 – 15	2-Severe 16 - 30	3-Total 31 - 45
☐ Lay out supplies ☐ Draw water ☐ Haul/heating water ☐ Standby for safety ☐ Help in/out of tub or shower ☐ Lay out clothing ☐ Help with zippers, buttons, and socks/shoes ☐ Comb/brush hair ☐ Remind/Monitor	☐ Tub bath/dry ☐ Sponge bath/dry ☐ Bed bath/dry ☐ Help with zippers, buttons and socks/shoes ☐ Help in/out of clothes ☐ Brush teeth ☐ Shave face ☐ Shave legs/ underarms ☐ Care for nails ☐ Wash hair ☐ Dry hair ☐ Wash hands/face ☐ Apply non-Rx lotion ☐ Set/roll/braid hair ☐ Apply makeup ☐ Remind/Monitor	☐ Total help with bath, including transfer in/out of tub, dressing, grooming, routine hair and skin care

E. MINOR MAINTENANCE OF ASSISTIVE DEVICE(S)

Exclude services already receiving from other sources.

Weekly Average Minute Range by Impairment Rating

1-Mild 0 – 10	2-Severe 11 – 15	3-Total 16 - 30
☐ Change batteries in equipment 1x/week ☐ Clean equipment such as wheelchair/ walker 1x/week ☐ Change tubing/filters ☐ Empty/filling of concentrator ☐ Remind/Monitor	☐ Change batteries in equipment 1x/week ☐ Clean respiratory equipment or wheelchair/ walker 3x/week ☐ Change tubing/filters ☐ Empty/filling of concentrator ☐ Remind/Monitor	☐ Total help for daily cleaning of equipment such as beside toilet, respiratory equipment, wheelchair/walker, nebulizer etc.

F. MOBILITY (transferring/walking)

Exclude services already receiving from other sources. The combined time for transfer and walking should not be more than 45 minutes.

Daily Average Minute Range by Impairment Rating

1-Mild 0 - 15	2-Severe 16 – 30	3-Total 31 - 45
☐ Help with adjusting/changing position ☐ Help putting on/off leg braces ☐ Some help in rising ☐ Standby help with walking or transfers ☐ Remind/Monitor	☐ Steady in walking/using steps ☐ Help with wheelchair ambulation ☐ Hands-on help with rising from a sitting to a standing position ☐ Much help with positioning or turning ☐ Remind/Monitor	☐ Total help with positioning or transferring from bed to chair, or walking

G. EATING

Exclude services already receiving from other sources and services for a feeding tube.

Per Meal Average Minute Range by Impairment Rating

1-Mild 0 - 5	2-Severe 6 - 15	3-Total 16 - 30
☐ Standby assistance ☐ Remind/Monitor	☐ Spoon feed ☐ Bottle feed ☐ Placing feeding devices ☐ Remind/Monitor Indicate meal(s) needing assistance: ☐ Breakfast ☐ Lunch ☐ Supper	☐ Total help with feeding

H. SELF-ADMINISTERED MEDICATION

Exclude services already receiving from other sources and services for persons unable to self administer medications.

Weekly Average Minute Range by Impairment Rating

1-Mild 0 – 10	2-Severe 11 – 15	3-Total 16 - 30
☐ Remind/Monitor	☐ Retrieve or open medication bottles for self-administration ☐ Remind/Monitor	☐ Total help with self-administered medications

I. DOCTOR PRESCRIBED SKIN CARE

Exclude services already receiving from other sources.

Daily Average Minute Range by Impairment Rating

1-Mild 0 - 5	2-Severe 6 – 15	3-Total 16 - 20
☐ Lay out supplies ☐ Remind/Monitor	☐ Apply lotion as directed by a doctor to skin 1x/day, or on 30% of the body or less ☐ Remind/Monitor	☐ Total help with skin care ☐ Apply lotion as directed by a doctor to skin more than 1x/day, or on 31% of the body or greater

J. HOUSEHOLD SERVICES

Exclude services already receiving from other sources.

Weekly Average Minute Range by Impairment Rating

Cleaning: 1-Mild 0 - 30	2-Severe 31 - 90	3-Total 91 - 120
Laundry: 1-Mild 0 - 30	2-Severe 31 - 90	3-Total 91 - 120
☐ Some help cleaning ☐ Make bed ☐ Pick up after tasks ☐ Minimal assistance with laundry ☐ Light hand washing ☐ Gather and sort laundry ☐ Remind/Monitor	☐ Pick up after tasks ☐ Clean floor of member living area ☐ Dust ☐ Clean bathroom ☐ Change linens ☐ Clean Kitchen - stove top, counters, dishes ☐ Clean refrigerator ☐ Empty and clean bedside toilet ☐ Carry out trash ☐ Consumer has special laundry needs and has: ☐ Washer/dryer ☐ Washer/no dryer ☐ No washer/dryer ☐ Remind/Monitor	☐ Total help with cleaning ☐ Total help with laundry

New Mexico Medicaid Utilization Review
Medical Eligibility Criteria for Nursing Facility (NF) Level of Care

Current Version Date: 11/04/02

Background: The Omnibus Reconciliation Act of 1987 eliminated a previous distinction between Medicaid Skilled and Intermediate care facilities and revised a baseline set of requirements for facilities providing long-term care to Medicaid recipients. Facilities which provide this level of care are termed Nursing facilities (NF). (Note: For purposes of the Medicare program, there are still facilities designated as "Medicare Skilled." This issue is separate from Medicaid issues.) To recognize that the clinical severity and resource utilization of recipients who require NF placement spans a considerable spectrum, New Mexico Medicaid has established two payment categories. These categories are termed "High NF" and "Low NF." They are constructs for payment methodologies and do not constitute different types of facilities. All NF's are required to be able to provide adequate services across the spectrum of severity/intensity encompassed by High NF and Low NF.

For NF care to be covered by New Mexico Medicaid, a recipient must be financially eligible and medically eligible. The criteria which follow address the second eligibility issue: medical eligibility. To be medically eligible, a recipient must meet the criteria for either Low NF or High NF. Note that a recipient may require substantial services, but if that array of services can be provided at a lower level of care (example: assisted living, shelter care, boarding home) the recipient would not meet medical eligibility requirements for NF coverage. Recipients who require skilled services on a time limited basis due to temporary self-limiting decline from a baseline functional level would not meet medical eligibility requirements for NF coverage. Also, if a recipient requires a level of care of higher intensity/resources than can be provided at a NF (example: acute care, acute rehabilitation, the Recipient would not meet medical eligibility requirements for NF coverage. In the past, there has been confusions about the relationship of skilled services to payment status. Note that a recipient certified at the Low NF rate may need and receive some degree of skilled level of care services. The mere provision of skilled level of care services to a Medicaid recipient does not per se constitute qualification for the High NF payment level.

Review decisions are based solely on documentation. The sources eligible for review are the Medicaid Long Term Care abstract, the clinical record or portions thereof, the Minimum Data Set (MDS), or facility written responses to requests for additional information. What follows are a set of review factors which are used to establish whether a recipient's clinical condition meets criteria for Low NF or High NF eligibility. If the clinical information available for review indicates the recipient meets criteria for a given level, the nurse reviewer may certify medical eligibility. (The nurse is <u>not</u> obligated to do so, however, if in his or her judgement criteria are "met" on their face, but not in their intent. In that case the nurse reviewer may refer the case for physician

review.) If the information does not substantiate that the recipient's condition meets criteria for the level being sought, the nurse reviewer is obligated to refer the case to physician review.

Definitions:

Skilled: For purposes of New Mexico Medicaid, the term "skilled" services may carry a different meaning than used in other programs, such as Medicare. Medicaid skilled services are direct ("hands-on") which can <u>only</u> be provided by a licensed professional acting within a defined scope of practice and in accordance with professional standards. Skilled services are those provided by registered nurses (RN), licensed practical nurses (LPN), licensed respiratory therapists (RT), licensed physical therapists (PT), licensed occupational therapists (OT), and licensed speech language pathologists (SLP or "speech therapists"). Skilled services are highly individualized and directed toward the evaluation, monitoring, treatment, or amelioration of <u>specific</u> clinical conditions. Skilled services are provided under direction of a licensed physician (MD or DO) and in accordance with a plan of treatment that is individualized and medically necessary.

Intermediate: Intermediate services are direct ("hands-on") services which can <u>only</u> be provided by certified (or similarly officially qualified) personnel who have received specialized training and are supervised by licensed professionals. Such services are directed toward specific needs of a resident as a result of a specific clinical condition. Examples include services provided by Certified Nurse Assistants (CNA) and Physical therapy aides.

Assistance: Assistance services are direct ("hands-on") services which are general in nature, principally independent of specific medical needs, which do not require extensive training in performance, and which require oversight by supervising professionals. Examples include food set-up and assistance with cutting food, bathing and grooming assistance, shopping assistance, money management, routine transfer assistance. (Assistance services may be provided by persons capable of providing professional or skilled services, but if the services do not <u>require</u> persons with that level of expertise, they remain assistance level services.)

Homemaker: Non-direct services which are general in nature and independent of specific medical needs. Examples include shopping, transportation, housekeeping.

Daily: For skilled, intermediate, and assistance services, at least once a day. For therapies, at least five times per week.

ADLs: Activities of Daily Living

- Dressing (Once clothes are accessible and fasteners appropriately modified, putting on and fastening clothes; putting on shoes.)
- Grooming (Once in front of appropriately modified sink, turning on water, washing face, shaving face, brushing teeth, combing hair.) Bathing (Once in an appropriately modified bath or shower, ability to turn on water and wash head and body.)
- Eating (Once in front of food, ability to bring food and fluid to mouth, chew and swallow.)
- Meal acquisition/preparation (Once food items appropriate to the recipient are in an appropriate, accessible location in residence, the ability to access and prepare the food in an edible state that over time meets age-appropriate nutritional needs. Includes preparation of cold foods re-heating of pre-made meals. Does not include meal planning, diet teaching, shopping, or issues of financial access. Does not include food choice or preference decisions of the recipient; the issue in question is capacity.)
- Transfer (Ability to move to and from bed and chair.)
- Mobility (Ability to move self from place to place by ambulation, wheelchair or other mechanically assisted means.)
- Toileting (Ability to properly sit on commode, adjust clothing properly, use commode, slush or empty commode, and clean perineal area.)
- Bowel/bladder control and management (Continence of urine and stool or ability to self-manage if incontinent or abnormal bladder function.)
- Taking daily, essential prescription medication (Assuming use of assistive dispensing devices and schedules as needed, the ability to recognize and properly self-administer prescription medications which are essential to maintaining life and health such that in the absence of such medication, mortality or serious morbidity would occur.)

IADLs: Instrumental Activities of Daily Living

- Answering telephone (includes use of special modifying equipment)
- Making a telephone call
- Shopping (once in store, selecting groceries and other items of necessity)
- Transportation ability (manner by which transports self from place of residence to other places beyond walking distance)
- Prepare meals (ability to prepare meals as desired, beyond simple meal acquisition/preparation; does not include meal planning)
- Laundry (ability to put clothes in washer or dryer, starting and stopping machine, removing clothes, drying clothes)
- Housekeeping (dusting, vacuuming, sweeping, routine cleaning of kitchen and bathroom)
- Heavy chores (moving furniture, yard work, windows, manually cleaning oven
- Taking non-essential medication (assuming use of assistive dispensing devices as needed, the ability to recognize and properly self-administer medications which are used for comfort or amelioration of symptoms, but which do not preserve life or avert serious morbidity)

- **Handling money (ability to properly pay, count change, pay bills, balance checkbook)**

Unstable: A clinical condition which requires daily skilled reassessment in order to prevent serious morbidity. Such reassessment must lead to clinical decision-making and a reasonable potential must exist that treatment goals may be modified and/or immediate skilled interventions might occur based on the results of the monitoring. The definition is broader than used in acute settings. An unstable condition does not necessarily mean that immediate death might result from lack of monitoring, only that serious morbidity might results. An unstable condition may be chronic and have no prognosis for improvement. Evolving processes for which monitoring is necessary in order to determine the seriousness of the process are also unstable conditions for the purposes of these criteria.

Medically Necessary: Medically necessary services are clinical and rehabilitative physical, mental or behavioral health services that:

- Are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;
- Are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual.
- Are provided within professionally accepted standards of practice and national guidelines;
- Are required to meet the physical, mental and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payor.

Application of the definition:

- A determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification or expansion of a covered benefit.
- The utilization review contractor is making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the Medicaid benefit package applicable to an eligible individual shall do so by:
  1. Evaluating individual physical, mental and behavioral health information provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training as appropriate;
  2. Considering the views and choices of the individual or the individual's legal guardian, agent or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views; and
  3. Considering the services being provided concurrently by other service delivery systems,
- Physical, mental and behavioral health services shall not be denied solely because the individual has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible individual solely because of the diagnosis, type of illness or condition.
- Decisions regarding benefit coverage for children shall be governed by the EPSDT coverage rules.

Medical Eligibility Criteria

Medical Eligibility for Low NF may be certified when one of the following criteria is met:

(1) The recipient's condition satisfies the General Eligibility Requirement for Low NF and one or more of Low NF Clinical Status Factors 1 - 8 are present.

OR

(2) The physician consultant determines that the recipient's condition satisfies the general Eligibility Requirement for Low NF and that there are factors present
which are equivalent to one or more of Clinical Status Factors 1 - 8.

Medical Eligibility for High NF may be certified when one of the following criteria is met:

(1) The recipient's condition satisfies the General Eligibility Requirement for High NF and one or more of High NF Clinical Status Factors 1 - 8 are present.

OR

(2) The physician consultant determines that the recipient's condition satisfies the General Eligibility Requirement for High NF and that there are factors present
which are equivalent to one or more of Clinical Status Factors 1 - 8.

Table of Clinical Status Factors

Note: Some factors from earlier versions have been incorporated into other factors. Their numbers have been left in the chart for data management purposes. They may be ignored.

TABLE OF CLINICAL STATUS FACTORS

Factor	High NF	Low NF	Not consistent with NF
NF General Eligibility Requirement	The recipient's functional level must first meet the general eligibility requirement for Low NF. In addition, the recipient has at least one condition or limitation such that it is medically necessary to receive (1) daily skilled monitoring and/or (2) daily skilled interventions to maximize medical stability or achieve restoration of function.	The recipient's functional level is such that two or more ADLs cannot be accomplished without consistent, ongoing, daily provision or some or all of the following levels of service: skilled, intermediate and/or assistance. The functional limitations must be secondary to a condition for which general treatment plan oversight of a physician is medically necessary.	Needs are too complex or inappropriate for NF, such that the recipient requires acute level of care for adequate diagnosis, monitoring, and treatment or requires inpatient based acute rehabilitation services. The recipient is completing the terminal portion of an acute stay and the skilled services are only being used to complete the acute therapy. Needs do not require an institutional long-term care setting, such as those which can be adequately addressed by home health care. The recipient requires services on an intermittent basis and has a functional level which does not require daily services at the skilled, professional or assistance level in order to accomplish ADLs. Recipient requires homemaker services to accomplish one or more ADLs, but is generally functional in accomplishing ADLs most days of the week.

TABLE OF CLINICAL STATUS FACTORS

Factor	High NF	Low NF	Not consistent with NF
1.A Medications	Administration of intravenous solutions and/or medications on a continuous basis. (See "Feeding" for parenteral nutrition administration issues.) OR Administration of medically necessary parenteral medications (except insulin, see below) OR Administration of varying doses of subcutaneous insulin based on a physician-determined and medically necessary sliding scale when such monitoring and decision for administration (1) occurs at least two times daily, (2) cannot be managed by the recipient, and (3) is in the setting of reasonable medical efforts to establish a baseline regarding dosing of intermediate and long-acting insulin. OR Administration of routine subcutaneous insulin twice daily (or more often) when the recipient is unable to self-administer insulin and also unable to report or manifest standard signs and symptoms of hypoglycemia such that each insulin injection requires increased skilled monitoring for presence of cerebral glycopenia (i.e., neurologic sequelae of hypoglycemia). OR Initiation of insulin therapy for a recipient who has not previously been on insulin (for the first thirty days of therapy). OR Administration of medications with well-established high risk profiles of side-effects mandating skilled nursing monitoring for	Intravenous fluids administered on rare occasion and for less than a day. (See "Feeding" for parenteral nutrition administration issues.) Includes TKO, KVO, Heparin Locks. OR Administration of routine, unchanging dose of subcutaneous insulin up to twice a day when the recipient is unable to self-administer (meaning if provided with a pre-filled syringe, would not be able to understand and administer.) The recipient must be able to report or manifest signs and symptoms of cerebral glycopenia and must not have had the need for side-effect related insulin adjustment for at least the past thirty days. OR Administration of medically necessary parenteral medications (except insulin) once per day. The patient is unable to self-administer. OR Administration of oral life-preserving prescription medications daily which the recipient cannot self-administer even if medications are set-up in assisted dispensing units and schedule reminders given. The medication must be significant enough that its absence would lead to significant morbidity or mortality.	Can administer own oral life and health preserving prescription medications if given assistance in scheduling and assisted dispensing units. Can administer own subcutaneous insulin in pre-filled syringes. Can administer own subcutaneous or intramuscular medications.

	predicted adverse reactions to administration which would require prompt medical intervention to prevent serious morbidity or mortality.		

TABLE OF CLINICAL STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
1.B. Respiratory therapy and supplemental oxygen	It is medically necessary for the recipient to receive 24-hour per day oxygen to prevent serious and potentially life threatening hypoxemia at rest and additionally it is medically necessary for the recipient to receive specific skilled monitoring and/or intervention on a daily basis to assure adequate oxygen delivery and/or assess respiratory depression. OR It is medically necessary for the recipient to receive respiratory therapy at least once per day such that in the absence of such therapy there is a significant risk of pulmonary compromise due to known and predictable complications of a physician-diagnosed condition. The necessary therapy cannot be self-administered by the resident. This factor includes tracheostomy suctioning.	It is medically necessary for the recipient to receive supplemental oxygen up to 24 hours per day and the administration of the oxygen requires skilled supervision and professional or assistance level care up to daily to prevent clinically predictable deterioration. The recipient must otherwise be unable to manage and self-administer supplemental oxygen. OR It is medically necessary for the recipient to receive respiratory therapy no less than three times per week to treat a condition amenable to such therapy. The therapy cannot be self-administered. This factor includes occasional or intermittent tracheostomy suctioning.	Recipient requires supplemental oxygen which can be self-administered. The oxygen needs are stable. The recipient does not require daily skilled observation. Recipient requires intermittent respiratory therapy that may be administered by family or self-administered in a non-institutional setting.

TABLE OF CLINICAL STATUS FACTORS			
Factor	**High NF**	**Low NF**	**Not consistent with NF**
1. C. Ventilator	The recipient is ventilator dependent, but otherwise medically stable and the facility provides chronic ventilator management capability.	N/A	The recipient is ventilator dependent and has medical needs which cannot safely be met at a NF.
1.D. Ostomy care	Recipient has a new ostomy (first 30 days), requires active training, and requires skilled nurse monitoring and intervention of the ostomy site. OR Recipient has complication of an ostomy requiring daily skilled assessment and intervention.	Recipient has an uncomplicated ostomy but is unable to adequately manage and care for the ostomy site such that without at least daily assistance services, there would exist a health or hygiene risk.	Recipient is able to manage and care for ostomy site with less than daily assistance.

TABLE OF CLINICAL STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
1.E. Management of decubitus ulcers (pressure ulcers) (Excludes other lesions, such as venous stasis ulcers.)	Recipient has one or more stage III or IV decubitus ulcers requiring skilled nursing intervention and monitoring. OR Recipient requires skilled nursing intervention for two or more stage II decubitus ulcers at <u>separate</u> anatomic sites.	Recipient requires skilled care for: (a) one or more stage I or stage II decubitus ulcers at a single site (e.g., sacrum) or (b) two or more stage I ulcers at multiple sites. Recipient would not be able to self-treat or prevent progression without daily assistance level of care.	Recipient has healed or healing decubitus ulcers in the context of eradication of factors which led to the development of the decubitus ulcer and is able to manage and care for the healing ulcer with intermittent assistance.

TABLE OF CLINICAL STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
1.F. Dressings (lesions other than pressure ulcers)	Recipient requires frequent sterile dressing changes (and/or irrigation) for significant, unstable lesions that require frequent nursing observation such as fresh, poorly healing, or infected wounds. Recipient must be unable to accomplish wound care without assistance.	Recipient requires sterile dressing changes (and/or irrigation) for significant, but stable, healing lesions. Recipient may be able to facilitate wound care, but must be unable to meaningfully accomplish wound care without assistance.	Recipient requires minimal assistance with dressing changes. Recipient is able to address wound care needs after training and mechanical assistance provided.
1.G. N/A	Incorporated into other factors	Incorporated into other factors	N/A

TABLE OF CLINICAL STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
1.H. Specialized Rehabilitative / restorative Procedures by Qualified Therapists	It is medically necessary that the recipient receive one or more of the following therapies on a daily basis: speech, physical, and/or occupational therapy. Therapy must be directed toward significant treatable functional limitations, which affect ADLs. Therapy must be directed toward significant treatable functional limitations, which affect ADLs. Therapy must be individualized, goal oriewnted, and in accordance with specific treatment plan goals in order to maximize recovery. In the aggregate, such therapy must occur no less than five (5) hours per week. Goals, expectation for improvement, and duration of therapy must be medically reasonable.	It is medically necessary for the recipient to receive one or more of the following therapies on less than a daily basis: speech, physical, and/or occupational therapy. Therapy must be directed toward significant treatable functional limitations which affect ADLs. Therapy must be individualized, goal oriented, and in accordance with specific treatment plan goals to maximize recovery. Goals, expectation for improvement, and duration of therapy must be medically reasonable.	The recipient requires maintenance speech, physical, and/or occupational therapy achievable on an outpatient basis. (Transportation needs are not considered.) The recipient requires maintenance speech, physical, and/or occupational therapy which can be performed independently or with home-based assistance.

TABLE OF CLINICAL STATUS FACTORS

Factor	High NF	Low NF	Not consistent with NF
1. I. Other NF Services Required	The recipient is comatose, in a persistent vegetative state, or is otherwise totally bed bound and totally dependent for all ADLs such that daily <u>skilled</u> intervention is <u>required</u> to prevent or treat specific, identifiable medical conditions which pose a risk to health. The recipient's ability to communicate needs, report symptoms, and participate in care is severely limited.	The recipient has physician diagnosed organic brain syndrome, dementia, or abnormal mental status such that the recipient is unable to manage ADLs independently and poses a significant, <u>documented</u> safety risk to self or others and such risk can only be managed in an observed, guarded, structured environment. OR Due to organic brain syndrome, dementia, spinal cord injury, or other causes, the recipient requires frequent <u>intermediate</u> and <u>assistance</u> services (such as repositioning), but the recipient does not medically <u>require</u> daily skilled interventions.	N/A

TABLE OF CLINICAL STATUS FACTORS

Factor	High NF	Low NF	Not consistent with NF
2. Feeding and Nutrition	PARENTERAL The recipient receives medically necessary parenteral nutrition (PN) solutions via non-permanent or permanent central venous catheter (Hickman, Groshong, Broviac, etc.), via peripherally inserted central catheter (PICC), or via peripheral access sites. ENTERAL The recipient receives some or all nutrition through a nasoenteric feeding tube (i.e., a tube placed through the nose) AND one or more of the permissive conditions for nasoenteric feeding at the Low NF level are <u>not</u> met. OR The recipient receives enteral nutrition via gastrostomy, jejunostomy, or other permanent tube feeding method and one or more of the permanent tube feeding permission conditions for Low NF and <u>not</u> met.	PERENTERAL N/A ETHERAL The recipient receives some or all nutrition via <u>nasoenteric</u> feeding tube. Tube placement and feeding must be uncomplicated. Tube feeding canot be managed by the recipient independently. All of the following permissive conditions must be met for Low NF as opposed to High NF: (a) The resident must be alert (not have a diminished sensorium); (b) The resident must have an intact gag reflex; (c) The resident must be able to be fed either upright in a chair or with a bed raised to at least 30 degrees and preferably 45 degrees. OR The recipient receives some or all nutrition via gastrostomy, jejunostomy, or other permanent tube feeding method and ALL of the following permissive conditions are met: (a) the tube placement site has been healed, mature, secure, continent, and non-infected for at least one month; (b) the recipient has been on a stable feeding solution regimen for at least one month with no complications (e.g.: tube clogging, pulmonary aspiration, uncontrollable diarrhea, dumping syndrome, glucose intolerance, hypoglycemia) which required skilled intervention.	Once fool is present in an accessible location, and reasonable accommodations made for functional limitations, the recipient is able to prepare it (open container, heat via microwave, oven, or range if necessary) and eat sufficiently to prevent protein-calorie malnutrition. OR The recipient requires a special diet for weight reduction, weight maintenance or gain, diabetes, hypertension, or other medical conditions and has no medical reason why the diet could not be followed. OR The recipient self-manages an enteral feeding tube.

TABLE OF CLINICAL STATUS FACTORS			
Factor	**High NF**	**Low NF**	**Not consistent with NF**
2. Feeding and Nutrition (continued)	ORAL N/A	ORAL The recipient requires at least assistance level assistance level care with <u>every</u> meal such that in the absence of daily assistance with meals, ineffective intake leading to protein-calorie malnutrition would occur or other serious medical consequence (e.g., aspiration) would occur.	
3. A. Mobility	The recipient is totally dependent on others for mobility from one location to another and the method of such mobility is highly specialized, accommodates specific clinical conditions, and by its nature <u>requires</u> skilled attendance to assure recipient safety during <u>each</u> episode of transportation.	For more than fifteen (15) days per month on average, the recipient is dependent on at least one other person for mobility beyond short distances (up to 30 feet). (Mobility refers to ambulation, ambulation with cane or walker, or use of wheelchair or other assist device.) OR The recipient is totally dependent on others for mobility, but such mobility is accomplished through assistance or routine transport devices (such as a wheelchair or gurney) and does not require skilled attendance at each episode.	The recipient is principally independent of assistance from at least one other person in mobility.

Factor	High NF	Low NF	Not consistent with NF
3.B. Transfer	The recipient is bed bound, unable to independently transfer, routinely requires transfer on a regular basis (at least three times per week), and has a clinical condition(s) such that the transfer itself is <u>not</u> routine, is reasonable viewed as posing unusual risks, and must be monitored by a licensed nurse to assure no clinical complications of the transfer have occurred.	The recipient cannot transfer from bed and chair without physical assistance of up to two persons. The transfers do not medically require observation by skilled personnel.	The recipient is able to transfer from bed and chair using mechanical and DME devices, technologies, and accommodations, but does not require direct physical assistance of another person for the majority of transfers.
4. N/A	This factor has been incorporated into the other factors.	This factor has been incorporated into the other factors.	This factor has been incorporated into the other factors.
5.A. Fluid intake and output	The recipient has a medical condition for which daily skilled monitoring of fluid balance is medically necessary to prevent or treat serious morbidity. The monitoring must be complete (all intake and output), must include at least weekly weights (unless contraindicated medically), and must be reviewed by the attending physician and licensed nursing staff at a frequency appropriate to the medical condition in order to specifically guide medical management of fluid balance.	The recipient has a medical condition for which skilled or intermediate observation of fluid intake no less than three times per week is medically necessary to prevent excess or insufficient intake of fluids. The results of this observation are reviewed by the attending physician and licensed nursing personnel at a frequency appropriate to the clinical condition in order to guide clinical management of fluid intake.	The recipient's fluid intake and output may require periodic assessment by nurses and/or physicians.

Factor	High NF	Low NF	Not consistent with NF
5.B. Vital Signs	The recipient has a medical condition for which daily or more frequent measurement of vital signs (pulse, blood pressure, respirations, and temperature) is medically necessary for guiding specific medical therapy. The vital signs must be reviewed for significance and used to make adjustments in the medical regimen accordingly. It must be clinically reasonable to believe that therapy will be altered by the findings and that outcomes can be meaningfully affected by the therapy.	The recipient has a medical condition for which measurement of vital signs no less than three times a week is medically necessary in an institutional setting. The findings must be used by licensed nursing personnel to guide management and/or used by a physician to guide the course of medical therapy. It must be clinically reasonable to believe that therapy will be altered by the findings and that outcomes can be meaningfully affected by the therapy. (Routine measurement of vital signs in accordance with facility policy but not directed toward specific medical needs does not meet this criteria.)	Periodic measurement of vital signs to verify continued stability.
6. Bowel and bladder function	Bladder dysfunction (such as neurogenic bladder) requiring sterile intermittent catheterizations by skilled personnel.	Chronic daily incontinence of bowel and/or bladder requiring assistance or intermediate services (including scheduled formal toileting programs), perineal care and cleansing that cannot be provided independently by the recipient.	Stress or other forms of intermittent incontinence which can be managed and cleansed by the recipient with minimal or occasional assistance.

Factor	High NF	Low NF	Not consistent with NF
7.A. Non-urinary catheter care	The recipient has an indwelling catheter other than a urinary catheter (e.g.: drains, t-tubes) which requires daily nursing care and observation. The recipient cannot manage the catheter independently.	N/A	The recipient has an indwelling catheter other than a urinary catheter which is planned to be short-term and managed by home-health care. The recipient is able to independently care for catheter related needs between home health visits.
7.B. Indwelling urinary catheter care	Due to unusual or unstable medical condition, daily skilled treatments (e.g.: instillation) or monitoring (e.g.: blood loss) are required in addition to routine chronic indwelling urinary catheter care (Foley or suprapubic).	The recipient requires skilled, intermediate, or assistance services with daily, routine indwelling urinary catheter care (Foley or suprapubic). The catheter requires only routine monitoring.	The recipient is able to manage daily, routine indwelling urinary catheter care with no assistance.
8. Conditions for which multiple sub-threshold conditions in the aggregate require NF level of care	There are a number of sub-threshold conditions and limitations such that the aggregate of the recipient's limitations and clinical needs requires daily skilled monitoring and/or intervention to reasonably prevent deterioration to an unstable state or to reasonable facilitate maximum restoration of function by the use of skilled techniques.	There are a number of sub-threshold conditions and limitations such that the aggregate of the recipient's limitations and clinical needs requires daily assistance, intermediate, or skilled services in order to maintain medical stability, and/or accomplish ADLs.	N/A

TABLE OF CLINICAL STATUS FACTORS			
Factor	**High NF**	**Low NF**	**Not consistent with NF**
9. Physician Consultant determines discharge status	For Internal Use	For Internal Use	For Internal Use
10. Physician consultant approval	For Internal Use	For Internal Use	For Internal Use
11. Physician consultant denial	For Internal Use	For Internal Use	For Internal Use
12. Administrative denial	For Internal Use	For Internal Use	For Internal Use

Explanation of Factors 8-11

- FACTOR 8: PHYSICIAN CONSULTANT DETERMINES DISCHARGE STATUS.

  THIS IS USED WHEN A NF RESIDENT WHO HAS RESIDED AT A NF FACILITY FOR A PERIOD OF TIME NO LONGER MEETS LOW NF CRITERIA AND THEY HAVE NO PLACE TO GO AND THERE IS NO ALTERNATIVE PLACEMENT IN THE COMMUNITY.

  WE APPROVE THEM A LNF LEVEL OF CARE, BUT REQUIRE THE PROVIDER TO KEEP MEDICAID U/R UPDATED ON THE AVAILABILITY OF ALTERNATIVE PLACEMENTS

- FACTOR 9: PHYSICIAN CONSULTANT APPROVAL

  THE REVIEW WAS SENT TO A PHYSICIAN PEER CONSULTANT AND IT WAS APPROVED

- FACTOR 10: PHYSICIAN CONSULTANT DENIAL

  THE REVIEW WAS SENT TO A PHYSICIAN PEER CONSULTANT AND IT WAS DENIED

- FACTOR 11: ADMINISTRATIVE DENIAL

  THIS REVIEWER WAS DENIED FOR SOME ADMINISTRATIVE REASON. THE MOST LIKELY EXAMPLE WOULD BE WHEN CMS DOESN'T ALLOW NEW ADMISSIONS TO A FACILITY BECAUSE OF A FAILED CMS SURVEY.