

PROVIDER BULLETIN

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PERSONAL CARE PROGRAM

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Frequently Asked Questions

1. How will MMAC conduct audits with regard to the number of authorized units and number of days in a month?

13 CSR 70-91.3010(1)(B)(2) provides: The personal care plan will be developed in collaboration with and signed by the participant. The plan will include a list of tasks to be performed, weekly schedule of service delivery, and the maximum number of units of service for which the participant is eligible per month. (emphasis added)

The first paragraph of 13 CSR 70-91.010 (Purpose statement) states: Specific details of the amount, duration, scope and limitations of services covered are included in the provider program manuals. (emphasis added)

Section 13.7.D(1) of the MO HealthNet Medicaid Personal Care Manual states in part:

The provider should *not* submit claims solely on the basis of the prior authorization, but *must* base claims upon documentation of actual services rendered. The participant may have been in the hospital or nursing home during a month, may have been away from the home visiting family or friends, or there may have been other reasons why all services which were prior authorized were *not* necessary or could *not* be delivered. The prior authorization merely establishes the maximum number of hours and types of services which may be given to a participant during a time period. All units billed to MO HealthNet must be supported by the documentation of delivery as described in this section.

Pursuant to the above, providers can only bill for actual services rendered. If, for example, a month only has 28 days, the provider cannot provide services on the 29th, 30th or 31st day. Specifically, if a service is authorized to be provided once a day, and the month only has 28 days, then the service can only bill for those 28 days.

2. Question: How will MMAC conduct audits with regard to signatures?

MMAC has posted guidance regarding this issue on its Web site under [Medicaid Fraud, Waste and Abuse](#).

3. Question: How will MMAC conduct audits with regard to nurse visits? Specifically, is a pre-printed form acceptable with a short narrative or short notes, and a signature (a form with check boxes), or does the whole form need to be handwritten?

A pre-printed form is acceptable with a short narrative or short notes, and a signature. The whole form does not have to be hand-written. If, however, the type of information required to be documented is not susceptible for being captured in a pre-printed form, then the information must be supplied. For example, if the required information is to provide the participant's vital signs, a "check the box" option would not be acceptable. The participant's actual vital signs must be documented on the form.

4. Question: Is it acceptable for an LPN to do certain activities on the authorized nurse visit, as opposed to an RN?

13 CSR 70-91.010(6)(D)4 provides: The RN may provide nail care for a diabetic or client with other medically contraindicating conditions, if the participant is unable to perform this task.

13 CSR 70-91.010(6)(D)7 provides that the visits authorized under section (6) except (6)(D)(6) (Advanced Personal Care Aide on-the-job training) may be carried out by an LPN, if under the direction of an RN.

Although section 335.099 RSMo states LPNs are "qualified" to perform certain services, it uses the qualifier "*as required by the department of social services*". The Department of Social Services requirements include that the LPN's work be under the direction of an RN. The Missouri State Medicaid Plan specifies that nurse services and personal care oversight are to be provided by an RN. For that reason, the Department of Social Services requires that the LPN's work be under the direction of an RN.

In order to comply with the above, MMAC requires documentation to prove that there is an RN on staff with the agency.

MMAC is responsible for administering and managing Medicaid (Title XIX) audit and compliance initiatives and managing and administering provider enrollment contracts under the Medicaid program. MMAC is charged with detecting, investigating and preventing fraud, waste and abuse of the Medicaid Title XIX, CHIP Title XXI, and waiver programs. For additional information about MMAC visit their Web site at mmac.mo.gov.

Provider Bulletins are available on the MO HealthNet Division (MHD) Web site at <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at <http://dss.mo.gov/mhd/global/pages/mednewssubscribe.htm> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

MO HealthNet Managed Care: The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MO HealthNet card or by calling the Interactive Voice Response (IVR) System at 573-751-2896 and using Option One for the red or white card.

**Provider Communications Hotline
573-751-2896**