

Section 2

Personal Care Services

Traditional Personal Care Services and Employment-related Personal Assistant Services

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Introduction

This manual is divided into two parts: Traditional Personal Care Services and Employment-related Personal Assistance Services (EPAS). The manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as *Section I: General Information of the Utah Medicaid Provider Manual (Section I: General Information)*.

The information in this manual represents available services when medically necessary. Services may be more limited or may be expanded if the proposed services are medically appropriate and are more cost effective than alternative services.

PART I – TRADITIONAL PERSONAL CARE SERVICES

1 General Information

1-1 General Personal Care Policy

Personal care services are an optional Utah Medicaid program authorized by Section 1905(a)(18) of the Social Security Act and 42 CFR 440.170(f). Part 1 of the Personal Care Manual addresses all State Plan covered personal care services with the exception of those services that are provided as part of the Employment-related Personal Assistance Services (EPAS) Program. For information related to EPAS Program services, see Part II of this manual.

The purpose of personal care services is to provide supportive care to participants in their place of residence, to maximize independence and to prevent or delay premature or inappropriate institutionalization through providing minimal assistance with the activities of daily living.

The provider may deliver services if the participant's needs do not exceed the level of personal care services as determined and documented by a licensed health care professional.

If the participant's needs exceed personal care services, the agency shall make a referral to a licensed health care professional or an appropriate alternative service provider.

Personal care services must be administered by agency staff only as ordered by a physician.

1-2 Fee-For-Service or Managed Care

This manual provides information regarding Medicaid policy and procedures for fee-for-service Medicaid members. This manual is not intended to provide guidance to providers for Medicaid members enrolled in a Managed Care Plan (MCP). A Medicaid member enrolled in an MCP (health, behavioral health or dental plan) must receive services through that plan with some exceptions called “carve-out services,” which may be billed directly to Medicaid.

Refer to the provider manual, Section I: General Information, for information regarding MCPs and how to verify if a Medicaid member is enrolled in an MCP. Medicaid members enrolled in MCPs are entitled to the same Medicaid benefits as fee-for-service members. However, plans may offer more benefits than the Medicaid scope

of benefits explained in this section of the provider manual. Contact the Medicaid Member Services hotline at (844) 238-3091 for further information.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid member enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a member enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a member's enrollment in an MCP. However, it is the provider's responsibility to verify eligibility and plan enrollment for a member before providing services. *Therefore, if a Medicaid member is enrolled in a MCP, a fee-for-service claim will not be paid unless the claim is for a "carve-out service."*

Eligibility and plan enrollment information for each member is available to providers from these sources:

- The Eligibility Lookup Tool: <https://medicaid.utah.gov/eligibility>
- AccessNow: (800) 662-9651

1-3 Acronyms and Definitions

Definitions of terms used in other Medicaid programs are available in *Section I: General Information of the Utah Medicaid Provider Manual (Section I: General Information)*. Definitions specific to the content of this manual are provided below.

Personal Care Service

- Services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease
- Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a Care Plan approved by the State
- Provided by an individual who is qualified to provide such service and who is not a member of the individual's family; and
- Furnished in a home, and at the State's option, in another location
- For purposes of this section, family member means a legally responsible relative

Home Health Agency

Public agency or private organization which is licensed by the Bureau of Health Facility Licensure and Certification under authority of Utah Code Annotated, Title 26, Chapter 21.

Personal Care Assessment

A visit made by a licensed registered nurse initially or at the required time of re-certification to assess the patient's functional level, the adaptability of the participant's place of residence to the provision of personal care, to determine the capability of the participant to participate in his own care and to identify family support

systems or individuals willing to assume the appropriate level of responsibility for care when the participant is unable to do so.

Licensed Health Care Professional

A registered nurse, physician assistant, advanced practice registered nurse, or physician licensed in accordance with Title 58, Occupational and Professional Licensing (Utah Code Annotated) by the Utah Department of Commerce who has education and experience to assess and evaluate the health care needs of the member.

Service Agreement

A written agreement for services between the participant and the personal care provider which outlines how the services are to be provided.

ICF/ID

Intermediate care facility for individuals with intellectual disabilities.

IMD

Institution for mental disease.

1-4 Personal Care Program Requirements

A. Program Access

- A physician must prescribe the necessary personal care services.
- Only a Home Health Agency licensed in accordance with Title 26, Chapter 21, may provide personal care services.
- Only a certified personal care aide or certified home health aide (performing only personal care level tasks, a licensed practical nurse, or a registered nurse, may provide the personal care services.
- A licensed registered nurse must supervise the provision of personal care services.
- Personal care services are a covered service only for participants who receive these services in their residence, not in an institution.
- Initially, a licensed registered nurse must complete a personal care assessment to assess the participant's functional level, the adaptability of the participant's residence for the provision of personal care, and to identify family support systems or individuals willing to assume the responsibility for care when the participant is unable to do so. A licensed registered nurse must also complete a personal care assessment at least at the required time of recertification or sooner if warranted by a change in the participant's condition.

B. Care Plan

Personal care service must be delivered according to a written Care Plan developed by provider agency staff, in consultation with the physician, and based upon physician orders. The Care Plan must include the following:

- Diagnoses
- Patient status
 - Mental status
 - Rehabilitation potential (optional)

- Functional limitations
- Service need:
 - Frequency/duration of service
 - Personal care tasks required
 - Equipment required (optional)
 - Nutritional requirements (optional)
 - Medications
- Discharge planning or referral
- Other identified appropriate services

The plan must be signed by the licensed registered nurse and incorporated in the Personal Care Agency's permanent record for the participant. All changes must be made in writing and signed by the licensed registered nurse or the agency staff receiving the physician's oral orders. All oral orders must be documented in writing on or before the next plan review.

Agency professional staff must alert the physician promptly of any changes in patient's condition that suggest a need to alter the Care Plan.

C. Supervision by a Registered Nurse

The licensed registered nurse must make a supervisory visit to the recipient's residence at least once every two months to assure that care is adequate and provided according to written instructions. The visit may be made either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are being met.

D. Periodic Review of Care Plan

The total Care Plan must be reviewed by the attending physician and signed by the Personal Care Agency personnel as often as the severity of the patient's functional limitation requires, or at least once every six months.

E. Record Keeping

- The Personal Care Agency shall maintain accurate and complete records. Records shall be filed, stored safely, and be easily accessible to staff and the Department.
- The participant record shall contain the following:
 - Participant's name, date of birth and address
 - Participant service agreement
 - Name, address, and telephone number of the individual to be notified in case of accident, emergency or death
 - Documentation of date and reason for the termination of services

2 Provider Participation Requirements

2-1 Provider Enrollment

Refer to provider manual, *Section I: General Information* for provider enrollment information.

2-2 Qualified Personal Care Providers

The individual providing personal care must provide service under the direction of a licensed registered nurse through a licensed Home Health Agency.

Persons qualified to provide personal care must be one of the following:

- Certified personal care aide
- Certified home health aide
- Licensed practical nurse
- Licensed registered nurse

3 Participant Eligibility

A Medicaid participant is required to present the Medicaid Identification Card before each service, and every provider must verify each participant's eligibility each time before services are rendered. For more information regarding verifying eligibility, refer to provider manual, *Section I: General Information, Verifying Medicaid Eligibility* or to the Eligibility Lookup Tool located at <https://medicaid.utah.gov/eligibility>.

3-1 Participant Eligibility Requirements

Personal care services are available to participants who meet the following conditions:

- The participant is non-bedbound
- The participant is unable to perform two or more of the following personal care tasks:
 - Self-administration of medications due to memory lapse
 - Body waste elimination, including the use of a urinal, commode, or bedpan
 - Bathing or showering, including getting in or out of the tub or shower
 - Skin care
 - Ambulation, including use of cane, crutches, walker, wheelchair, or other assistive device
 - Personal grooming, including oral care, hair care, shaving (with electric razor), dressing, and nail care
 - Nutritional requirements, including meal planning, preparation, cleanup, and motivation to eat
- The participant needs personal care to:
 - Maintain the capacity to function, delay disease progression, or prevent regression and complications; or

- Achieve satisfactory level of comfort and dignity during terminal stages of an illness; or
- Receive assistance while recovering from an acute condition.

4 Program Coverage

4-1 Covered Personal Care Services

Personal care services are covered benefits when provided by a Home Health Agency licensed in accordance with Utah Code Annotated Title 26, Chapter 21. Services are delivered by a certified personal care aide or a home health aide (performing only personal care-level tasks), a licensed practical nurse, or a licensed registered nurse. Personal care services are prescribed by a physician and are provided under the supervision of a registered nurse.

Services provided by the personal care provider may include:

- Reminding the patient to take medication, and observing the patient who is able to self-administer medication
- Providing minimal assistance with, or supervision of, bathing and personal hygiene including shampoo and hair care, skin care according to the patient's Care Plan, and shaving (with electric razor only)
- Providing nail care as outlined in the patient's Care Plan
- Providing meal assistance, including special diets, meal planning, preparation, feeding if necessary, and cleanup for the individual participant
- Providing oral hygiene, including tooth or denture care
- Assisting with ambulation, including arm support, use of cane, crutches, walker, wheelchair, or other assistive device
- Assisting with bladder and bowel requirements or problems, including helping the patient to and from the bathroom, or assisting non-bedbound patients with bedpan routines, but excluding assistance with enemas, suppositories, or ostomy care
- Making brief occasional trips outside the home for the patient to receive medical examination or treatment, or for shopping to meet the patient's health care or nutritional needs
- Taking proper measures for the patient's safety and comfort, including good hand washing techniques, proper disposal of body waste, and explanation and application of smoking precautions
- Administering emergency first aid
- Observing and reporting significant changes in the patient or the home environment
- Performing household services (if related to a medical need) as are essential to the patient's health and comfort in the home, e.g., changing of bed linens, or rearranging furniture to enable the participant to move about more easily in the home

Personal Care Procedure Codes

T1001 Initial and Subsequent Nurse Assessments to Establish Care Plan

An initial nurse assessment by a licensed registered nurse must be provided for the purpose of assessing the participant's needs and functional level and establishing the Care Plan.

T1019 Personal Care Service

Personal care services, per 1 hour, not for an inpatient or resident of a hospital, nursing facility, ICF/ID or IMD, part of the individualized plan of treatment.

T1021 Home Health Aide or Certified Nurse Assistant, per visit

Please see the Utah Medicaid Home Health Services Provider Manual for all policy requirements related to code T1021.

Utilization Modifiers

- T1001-SE Utilization Modifier SE is required to differentiate personal care assessment from the home health assessment performed in the Home Health State Plan Service category. SE signifies a personal care assessment rate set at 36.69% of the Home Health Agency assessment base rate. The SE modifier is required to be used on all State Plan Personal Care service claims for T1001.
- T1019-TN Utilization Modifier TN is optional. This modifier is to be used to identify a rural enhancement to the routine service rate. TN signifies a Rural Enhancement rate set at 175% of the routine base rate for T1019. Use of the TN modifier is limited to services provided by a provider based in a rural county and in which a travel distance of 50 miles or more round trip, to point of service occurs. In the case of multiple coordinated visits as part of a single trip, the TN modifier may only be claimed for each specific visit when the travel distance from the previous visit to that visit is 50 or more miles and the rural requirements are met.

[For [additional] coverage information, refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at: <https://medicaid.utah.gov>.]

4-2 Non-Covered Services

- Providers may not provide personal care services for a participant on the same day that Medicaid state plan home health aide services are provided.

4-3 Limitations

- Personal care services (T1019) are limited to 60 hours per month and require prior authorization.
- Personal care services should not be confused with services which would more appropriately be provided by persons who provide chore services in the home. Examples of chore services which are clearly not to be regarded as personal care are as follows:
 - Cleaning of floor and furniture in areas not occupied by the participant. For example, cleaning of the entire living area if participant occupies only one small room;
 - Laundry, other than that incidental to the care of the participant. For example, laundering of clothing and bedding for the entire household, as opposed to simple laundering of the participant's personal laundry.

5 Billing

Refer to the provider manual, *Section I: General Information*, for detailed billing instructions.

5-1 Prior Authorization

Prior authorization may be required for certain services. Failure to obtain prior authorization can result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization *before* providing services. Exceptions may be made, with appropriate documentation, if the service provided is emergent or the participant is retro-eligible for the dates of service requested or when a specific grace period is stated in the program specific provider manual.

Prior authorization information is provided in the provider manual, *Section I: General Information*. Code specific coverage and prior authorization requirements are provided on the Medicaid website, Coverage and Reimbursement Lookup Tool at: <https://medicaid.utah.gov>.

Prior Authorization Certification Period

Prior authorization for personal care services should be requested for six months unless the care needs indicate that less time is required.

Initial Requests:

The Personal Care Agency will be given 10 days from the start of services to submit all required documentation, including the completed "Request for Prior Approval" form, Care Plan, and any supporting documentation that would substantiate medical necessity for the requested services. If the request is received more than 10 days after the start of services, the authorization will begin on the day that the completed request and all required documentation is received.

Re-certification Requests:

A new prior authorization request including "Request for Prior Approval" form, Care Plan, and any supporting documentation that would substantiate medical necessity for the requested services will be required every six months or sooner if change in authorization is needed. The request for the new certification period must be received within 10 days of the re-certification period start date. Care and service needs and the Care Plan must be reviewed and a new prior authorization will be issued if the requested services are approved. If the request is received more than 10 days after the start of the new certification period, the authorization will begin on the day that the completed request and all required documentation is received.

Prior Authorization requests should be faxed to:

(801) 536-0157

or

Mailed to: Utah Medicaid Prior Authorization Unit

P.O. Box 143111

Salt Lake City, UT 84114-3111

Criteria for Review of Prior Authorization Requests (T1019)

The Medicaid agency will use the following criteria to evaluate prior authorization requests. Criteria include the following:

1. A current prescription for personal care service by a physician as evidenced in the physician's orders;
AND
2. Documentation stating that the patient is non-bedbound; AND
3. Documentation of the patient's inability to perform two or more of the following personal care service tasks:
 - a. Needs reminding in self-administration of medications
 - b. Elimination, including the use of a urinal, commode, or bedpan
 - c. Bathing or showering, including getting in and out of the tub or shower
 - d. Skin care
 - e. Ambulation, including use of cane, crutches, walker, or wheelchair
 - f. Personal grooming, including oral care, hair care, shaving (with electric razor), dressing, or nail care
 - g. Nutritional requirements, including meal planning, preparation, cleanup, motivation to eat, etc.AND
4. Documentation that the participant needs personal care to:
 - a. Maintain capacity to function, delay disease progression, or prevent regression and complications;
OR
 - b. Achieve satisfactory level of comfort and dignity during terminal stages of an illness; OR
 - c. Receive assistance while recovering from an acute condition
5. Participant does not require any of the following home health aide services:
 - a. Having vital signs or temperature taken, urine tested, urine or stool specimens collected
 - b. Need enemas, external catheter applied or removed, external catheter drainage tubing and bag changed or emptied
 - c. Bag changed on well-regulated ostomies; active or passive range-of-motion exercises; dry dressings changed

Note: If services listed in 5 (Home Health Aide Service) are required, a personal care attendant is not the appropriate provider type. Please see the home health provider manual for home health aide prior authorization requirements.

Criteria for Review of Prior Authorization Requests for Additional Nurse Assessment (T1001)

A completed prior authorization request form should be submitted prior to the service being provided and must include documentation that patient's condition has changed significantly enough to require an additional nurse assessment.

5-2 Patient Notices and Rights

The personal care provider may not charge a participant for services that are denied because the provider failed to advise the participant that the services were not covered by Medicaid or because the provider failed to follow prior authorization procedures. The provider may charge the participant for services that are not covered by

Medicaid when the provider has advised the patient in advance that the services are not covered and the patient has agreed to pay for the services.

5-3 Fair Hearings

The Medicaid agency will notify the participant whenever all or part of the services requested on a prior authorization request are denied. The notice will specify the services for which payment has been denied, the regulations, rules or criteria upon which the action has been taken, and the appeal rights provided. A copy of the denial notice will be mailed to the requesting personal care provider.

PART 2 – EMPLOYMENT-RELATED PERSONAL CARE SERVICES

1 General Information

1-1 General Policy

Employment-related Personal Assistance Services (EPAS) is an optional Utah Medicaid program authorized by Section 1905(a)(18) of the Social Security Act and 42 CFR 440.170(f). Part 2 of the Personal Care Manual addresses State Plan covered EPAS. For information related to traditional personal care services, see Part 1 of this manual.

The manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as *Section I: General Information of the Utah Medicaid Provider Manual (Section I: General Information)* and *the Physician Services Utah Medicaid Provider Manual*.

EPAS provides services to Medicaid participants with disabilities who work and need personal assistance in order to successfully maintain their employment. EPAS may be delivered by a Personal Care Agency licensed to provide personal care services or through the Self-Administered Services (SAS) delivery option. The SAS delivery option allows the Medicaid participant to employ and directly supervise the EPAS employee who meets provider qualifications established by the Medicaid Agency. Medicaid participants who choose to receive EPAS through the SAS delivery option must utilize a Financial Management Service Agency to ensure that the necessary employer related duties and tasks, including managing the EPAS employee's payroll, are properly completed.

1-2 Fee-For-Service or Managed Care

EPAS services are only available on a fee-for-service basis. EPAS is a carve-out service and is not available through Managed Care Plans.

1-3 Acronyms and Definitions

Activities of Daily Living (ADLs)

Basic self-care tasks that people tend to do every day without needing assistance. ADLs include: eating, toileting, dressing, grooming, maintaining continence, bathing, walking and transferring (such as moving from bed to wheelchair).

Assessor

A Licensed Clinical Social Worker or a Registered Nurse who conducts the required EPAS functional assessment(s) of the Medicaid participants.

BACBS

Bureau of Authorization and Community Based Services.

Disability

As defined by established disability criteria according to the Social Security Administration or the Medical Review Board.

DSPD

Division of Services for People with Disabilities.

DWS

Division of Workforce Services.

EPAS

Employment-related Personal Assistant Services.

EPAS Specialist

Individual employed by the State Medicaid Agency who provides overall program management and oversight of the EPAS program.

FMS

Financial Management Services is the service provided in support of self-administered services that ensures the necessary employer related duties and tasks, including managing the EPAS employee's payroll, are properly completed.

HCPCS

Healthcare Common Procedure Coding System.

Instrumental Activities of Daily Living (IADLs)

These activities are not necessary for fundamental functioning but allow the individual to live independently in a community. IADLs include: meal preparation, ordinary housework and basic home maintenance, managing finances, managing medications, phone use or other communication devices, shopping, and transportation (driving or handling public transit).

LOC

Level of Care.

MDS-HC

Minimum Data Set for Home Care. The standard comprehensive assessment instrument used in the EPAS program.

PA

Personal Assistant.

SAS

A self-administered service is a service delivery option that allows the Medicaid participants to employ and directly supervise the EPAS employee who meets provider qualifications established by the Medicaid Agency. Under this service delivery method, the Medicaid participants is responsible for hiring, training, supervising, setting work schedule, and carrying out disciplinary actions. Medicaid participants who choose to receive EPAS through the SAS delivery option must utilize a Financial Management Services provider to ensure that the necessary employer related duties and tasks, including managing the EPAS employee's payroll, are properly completed.

SC

Service Coordinator.

2 Provider Participation Requirements

Refer to provider manual, *Section I: General Information* for general provider enrollment information.

Any willing provider that meets the qualifications defined below may enroll at any time to provide EPAS services. To enroll as an EPAS provider contact the EPAS Specialist. The EPAS Specialist will facilitate completion and submission of the required Medicaid provider application. The provider is only authorized to provide the EPAS services specified and approved in their Medicaid provider agreement.

2-1 Service Coordinator Enrollment

Service Coordinator Agencies are responsible for the ongoing management of the EPAS participant's case. Management of the case includes: verification of employment, verifying and assisting the participant to maintain Medicaid eligibility, assisting the participant with training the EPAS personal assistant, creating and implementing Care Plans, and scheduling and coordinating with the EPAS Assessor to complete periodic reassessments. Service Coordinator provider qualifications include:

- Possess a Bachelor's Degree, preferably in Human Services or related field or can substitute a year of equivalent work providing services to the target population for each year of the required education
- Possess a valid State or Federal photo identification
- Have an applicable business license
- Pass a Utah criminal history and background check
- Have general liability/professional liability insurance
- Attend the mandatory EPAS Service Coordinator Training provided by State Medicaid Agency staff and demonstrate required competencies for service coordination, protocols and procedures
- Complete the Utah Medicaid Provider Application

- Complete Attachment A
- Complete and agree to provider responsibilities in Attachment B

2-2 Financial Management Services Agency Enrollment

If an EPAS participant chooses to use a non-agency individual to provide their personal care services, a Financial Management Services Agency must also be used to assist the EPAS participant in payroll and employer related taxes. Fiscal Agencies are responsible for processing paychecks and issuing them in a timely manner. Financial Management Services provider qualifications include:

- Possess a business license
- Pass a Utah criminal history and background check
- Possess a valid State or Federal photo identification
- Complete the Utah Medicaid Provider Application
- Complete Attachment A

2-3 Assessor Enrollment

EPAS Assessors are responsible to conduct EPAS assessments to determine participants' program eligibility and to evaluate needs for Care Plan development. The Minimum Data Set- Home Care (MDS-HC) assessment tool is the required assessment tool. EPAS Assessor provider qualifications include:

- Must be a Licensed Clinical Social Worker (LCSW) or a Registered Nurse (RN)
- Pass a Utah criminal history and background check
- Possess a valid State or Federal photo identification
- Attend the mandatory EPAS Assessor training provided by state Medicaid agency staff and demonstrate required competencies for completing assessments, protocol and procedures
- Complete the Utah Medicaid Provider Application
- Complete Attachment A

2-4 Personal Care Agency Enrollment

EPAS may be delivered by a Personal Care Agency licensed to provide personal care services or through the Self-Administered Services (SAS) delivery option. The SAS delivery option allows Medicaid participants to employ and directly supervise the EPAS employee who meets provider qualifications established by the Medicaid Agency. EPAS personal care services include physical assistance and cognitive cuing to direct self-performance of necessary activities. Medicaid participants who choose to receive EPAS through the SAS delivery option must utilize a Financial Management Services provider to ensure that the necessary employer related duties and tasks, including managing the EPAS employee's payroll, are properly completed.

Personal care services may be delivered by an agency licensed to provide personal care services outside of a 24-hour supervised living setting, in accordance with Utah Code Annotated, Title 26, Chapter 21.

Personal Care Agency Provider Qualifications:

Personal Care Agencies must be licensed in the State of Utah in accordance with UAC R432-725 Personal Care Agency Rule.

SAS Provider Qualifications:

- Must be at least 16 years of age
- Possess a valid State driver's license
- Possess automobile liability insurance if providing transportation services.
- May not be the spouse of the EPAS participant
- May not be the parent of an EPAS participant under the age of 18
- Attend the mandatory EPAS Personal Assistant training provided by the recipient's chosen Service Coordinator upon every Care Plan renewal
- Sign and complete the Personal Assistant Employment Agreement Form annually

3 Participant Eligibility

3-1 Eligibility for EPAS Services

To be eligible for the EPAS program the Medicaid participant must:

- Meet the SSI definition of disability
- Be gainfully employed in an integrated community setting making at least minimum wage.
 - An integrated community setting is defined as a workplace or environment where there are persons with and without disabilities employed within the same company.
 - Gainful employment is defined as an employment situation where the employee receives consistent work and payment of at least minimum wage from an employer.
- Be employed and working for an employer at a minimum of 40 hours per month or
 - Enrollment onto the EPAS program is determined on a case-by-case basis. If the applicant is unable to work 40 hours per month due to company restrictions, location, or other circumstances, despite the applicant's capacities to work 40 hours per month, the applicant may submit rationale to petition to be enrolled onto the EPAS program.
- Be self-employed and able to demonstrate substantial income and specific work activity each month
- Need a Personal Assistant in order to remain employed

The participant is not eligible if:

- The participant resides in an institutional setting
- The participant is enrolled in a 1915(c) Home and Community Based Waiver Program

General Eligibility

A Medicaid participant is required to present the Medicaid Identification Card before each service, and every provider must verify each participant's eligibility each time before services are rendered. For more information regarding verifying eligibility, refer to provider manual, *Section I: General Information, Verifying Medicaid Eligibility* or to the Eligibility Lookup Tool located at <https://medicaid.utah.gov/eligibility>, or from these additional sources:

- AccessNow: (800) 662-9651
- Medicaid Customer Service: (801) 538-6155

3-2 EPAS Participant's Freedom of Choice of Service Providers

At the time of initial Care Plan development and any time a change is made to the participant's Care Plan, the Service Coordinator or EPAS Specialist will present the participant with a Freedom of Choice Consent Form.

The Freedom of Choice Consent Form allows the participant to declare their choice of available services and providers within their county of residence. The Service Coordinator and EPAS Assessor must maintain a signed copy of this form in the participant's case records.

4 Program Coverage

4-1 Covered Services

Personal Assistant Services

Personal Assistants may only provide assistance with ADLs or IADLs in support of assisting the EPAS participant to maintain employment. Services are not available for other household participants living with the Medicaid participant.

A. ADLs include the following services:

1. Mobility in Bed
2. Transferring
3. Locomotion in and outside of home
4. Dressing
5. Eating
6. Toileting including: (excludes assistance enemas, suppositories, catheters and ostomy care or insertion of feminine hygiene products).
7. Personal Hygiene
8. Bathing

B. IADLs include the following services:

1. Meal Preparation
2. Ordinary Housework
3. Laundry
4. Managing Finances (includes assistance with budgeting, paying bills, and maintaining Medicaid eligibility spend downs or Medicaid Work Incentive requirements).
5. Medications Reminders and Cueing (In compliance with the Utah Nurse Practice Act, personal assistants may not administer medications, including the application of prescription ointments or creams).
6. Shopping to include purchase of items such as groceries, personal hygiene products, prescription medications, uniforms or work clothing. Shopping for clothing will be authorized on an occasional and limited basis with the intent of assuring that the participant is dressed appropriately for work as per the authorized Care Plan.
7. Transportation
 - a. Accompanying the individual to and from public transportation for work.
 - b. Transporting the participant to and from work
 - i. Note that time is only allotted for when the participant is actually in the vehicle.
 - c. Transporting the individual to go shopping for items described in Item 6. above
 - d. Self-employed participants who require specific products in order to maintain their business may be allotted time for purchasing these products as per the authorized Care Plan.
 - e. Transporting the individual to and from the pharmacy to pick up or drop of prescription medication orders.

EPAS Assessment Services

A Licensed Clinical Social Worker (LCSW) or a Registered Nurse (RN) who has received initial and annual training by the State Medicaid Agency must conduct an EPAS Assessment utilizing the Department's required assessment tool, the MDS-HC assessment instrument. (One mandatory training for EPAS assessors will be conducted each year).

The MDS-HC Assessment is a standardized, minimal assessment and screening tool designed for clinical use. The MDS-HC Assessment Form consists of items and definitions that should be used as a guide to structure a clinical and social assessment in planning for community-based care and services.

The assessment process requires communication with the person and primary caregiver/family member (if available), observation of the person in the home environment, and review of secondary documents when available. Where possible, the person is the primary source of information. EPAS requires that whenever possible, the MDS-HC assessment should be performed during a face-to-face visit within the individual's home. In special circumstances, the EPAS Specialist may pre-approve the completion of the assessment in another setting or over the phone.

Items on the MDS-HC Assessment Form flow in a logical sequence and can be completed in the order in which they appear. However, the assessor is not bound by this sequence. Items may be reviewed in any order that works for the assessor and the participant.

To determine EPAS eligibility, a score will be derived from the completed assessment based on the nine critical areas of the assessment.

The EPAS Assessor will utilize the MDS-HC Criteria Scoring Form to determine if the applicant meets the minimum eligibility criteria for the program. The individual must score > 0 on five or more of the nine criteria listed on the Scoring Form. Instruction and training on the use of the Scoring Form will be included in the EPAS Assessor's mandatory training.

Service Coordination Services

As part of the Care Planning process, the Service Coordinator is responsible to review the results of the MDS-HC Assessment and the MDS-HC Criteria Scoring Form. The Service Coordinator is responsible for developing a written individualized Care Plan.

The plan must include:

- (a) The name, date of birth, and Medicaid ID of the individual
- (b) Employment data
- (c) Care plan type selection of initial, annual, or change in information
- (d) Billing or HCPC codes for Service Coordination, Financial Management Services Agency, and Personal Attendant Services
- (e) Name of chosen service providers
- (f) The recommended amount and frequency of services. Explained in both weekly and monthly hours.
- (g) The Care Plans beginning and end date of services
- (h) Other employment or community supports being utilized by the individual
- (g) The basis for the need of ADL or IADL assistance, including MDS-HC impairment score data
- (h) Signatures from the participant or representative, Service Coordinator, and State Medicaid Agency.

Annual Assessment and Care Plan Process

All Assessments for active EPAS participants are valid for a period of 12 months. Care Plans must be developed within 30 calendar days of each new assessment; therefore, Care Plans must be completed annually as well. The process of conducting the annual assessment process consists of the following activities:

1. The Service Coordinator and EPAS Assessor are responsible to coordinate and regulate appointments in a timely manner for all annual EPAS reviews. The EPAS Assessor or Service Coordinator will initiate the need for a new assessment.

2. The EPAS Assessor and Service Coordinator must verify the Medicaid eligibility of the participant before providing any services.
3. The Assessor must complete the annual reassessment in the same calendar month as the previous assessment.
 - i. It is possible to complete several assessments within a one year time frame due to a possible change in health status or circumstance of the EPAS participant. Each time a new assessment is completed a new Care Plan must also be developed.
4. The Service Coordinator has 30 calendar days from the date of the completed assessment to develop an annual renewal Care Plan. The Care Plan must be turned into the EPAS Specialist 10 days prior to the begin date of the new Care Plan.
 - i. For Example: If a participant's new Care Plan begin date was January 1, the Service Coordinator must have the new Care Plan turned into the EPAS Specialist 10 days prior, on Dec 21, in order to give the EPAS Specialist time to review and approve the Care Plan prior to its begin date.
 - ii. Please note that although an initial Care Plan may begin any day of the month, an annual Care Plan must begin at the first of the month. Example: A participant's initial Care Plan was authorized to begin January 13, 2015, however, upon developing the participant's annual Care Plan, the Care Plan must start on the first of the month or January 1, 2016.
5. Once the Care Plan, MDS-HC, and all other initial paperwork are turned into the EPAS Specialist, the EPAS Specialist will review the Care Plan and assessment for validity and justification of hours allotted to the participant. The approved Care Plan is the authorization for the EPAS Assessor, Service Coordinator, and Personal Care Services. However, Financial Management Service Agencies will receive a separate authorization/ budget for each EPAS participant.

4-2 Non-Covered Services

- Medical Transportation, including transportation to doctor appointments or other medically related services
- Work Training including job coaching, job training, or reasonable accommodations that an employer is required to provide under the Americans with Disabilities Act).
- Participants who are self-employed may not use their Personal Assistant as an employee in their business
- Cleaning EPAS participant's vehicle, running miscellaneous errands, or providing any other services not listed under Covered Services.
- Taking care of EPAS participant's personal pets or animals.
- Watching, or tending to EPAS participant's children or relatives.
- Behavioral supports.

5 Billing

Refer to the provider manual, *Section I: General Information*, for detailed billing instructions.

5-1 Billing and Rate Codes

HCPCS	Description	Provider Type	Unit (15 min = 1 unit)	Rate (Unit/hour)
T1028	Assessment	68	Per Encounter	Rate can be found on Coverage and Reimbursement Look-Up Tool*
S5125	Self-Directed Service Attendant Care	54	15 min	Self-Directed Service Attendant Care is 61% of the Maximal Allowable Rate (MAR) for Traditional Attendant Care*
S5125	Traditional Attendant Care	54	15 min	Rate can be found on Coverage and Reimbursement Look-Up Tool*
T2040	Fiscal Management Service	68	Monthly	Rate can be found on Coverage and Reimbursement Look-Up Tool*
T2024	Service Coordination	68	15 min	Rate can be found on Coverage and Reimbursement Look-Up Tool*

* Utah HCPC rates are found on Medicaid’s Coverage and Reimbursement Look-up Tool:
<https://medicaid.utah.gov/coverage-and-reimbursement>

5-2 Application Requirements and Prior Authorization of EPAS Services

The application process and performance of the initial assessment consist of the following activities:

- A. An applicant submits their application into the EPAS Specialist. The EPAS Specialist reviews the application to determine if the applicant meets basic program eligibility. If the EPAS Specialist determines that the applicant meets basic program eligibility, the Specialist will send the applicant an EPAS program packet that includes the Freedom of Choice Consent Form. Once the applicant completes and submits the paperwork back to the EPAS Specialist, a referral from the EPAS Specialist to the chosen EPAS Assessor and Service Coordinator is made.
- B. The EPAS Assessor and Service Coordinator must first verify the Medicaid eligibility of the participant before providing any services, and work together to assure appointments are set up with the participant in a timely matter.

- C. The EPAS Assessor has 30 calendar days from the date of referral from the EPAS Specialist to complete the initial assessment and give it to the participant's Service Coordinator and EPAS Specialist. The Service Coordinator has 30 calendar days from the date the initial assessment was completed to develop the participant's Care Plan and submit it to the EPAS Specialist.
- D. Once the Care Plan, MDS-HC, and all other initial paperwork are turned into the EPAS Specialist, the EPAS Specialist will review the Care Plan and assessment for validity and justification of hours allotted to the participant. The approved Care Plan is the authorization for the EPAS Assessor, Service Coordinator, and Personal Care Services. However, Financial Management Service Agencies will receive a separate authorization/ budget for each EPAS participant.

All EPAS authorizations will contain the following information:

1. The HCPCS billing code and associated rate
2. The amount and frequency of the service ordered
3. The start and end date of the services
4. EPAS Specialist signature and date

6 Suspension of EPAS Services

6-1 Holds and Suspensions

When the participant is not meeting the program requirements on a temporary basis, the EPAS Specialist may place an EPAS participant's case on hold. Reasons for placing a participant's case on hold include:

- The participant's employment is terminated for any reason (quit, fired, laid off).
 - The participant has 30 days from their last day of work to find a new job before they will be disenrolled from the program. If the participant is working with Vocational Rehabilitation or similar job coaching company, the participant will have 60 days to find a new job before the case is terminated.
- The participant is hospitalized or admitted to a nursing facility.
 - If the participant remains in the hospital or nursing facility longer than 60 days, the participant will be disenrolled from the program.
- The participant is missing.
 - If the participant is missing for more than 30 days they will be disenrolled from the program.
- The participant is on vacation.
 - If the participant is on vacation for less than thirty days, EPAS services will be placed on hold. If the participant is on vacation for more than 30 days they will be disenrolled from the program.
- The participant goes on maternity leave.

- If the participant is receiving personal time, or annual pay while away on their maternity leave, their services may continue uninterrupted. However, if the client is receiving no income from their place of employment during their maternity leave their services will be suspended until they return back to work.
- The participant did not pay their Medicaid Work Incentive (MWI) premium or spend down for the month.
 - If the participant does not pay their premium or spend down, their services will be on hold until the outstanding amount is paid. If the participant misses two months or a 60 day period of paying their MWI, services will be discontinued, and participant disenrolled.
- If the participant does not work the minimum of 40 hours a month due to sickness or injury, their case may be placed on hold.
 - If the participant's illness or sickness makes them absent from work longer than two work weeks, the participant's case will be placed on hold until they have returned back to work and able to continue performing the 40 hour minimum per month.
 - If the participant is consistently not meeting the 40 hour minimum work hour criteria, their case may go under review to be discontinued. Each situation will be evaluated on a case by case basis by the EPAS Specialist.
 - If the client has personal, sick, or annual time in which they may still receive income when they are not working, their service will continue uninterrupted.
 - Self-employed participants who fail to submit their monthly income financial statements, ledgers, work activity logs, or federal tax returns will be disenrolled. (All work hours must be accounted for in relation to their business. If an activity does not have the potential to produce a new consumer or revenue then the activity, it is not considered to be work related).

6-2 Disenrollment, Termination and Reenrollment of EPAS Services

Participation in the EPAS program is voluntary. Participants may disenroll from the program at any time. The EPAS Specialist will conduct periodic reviews of cases that have been placed on hold to determine if program termination is warranted. In addition, the EPAS Specialist will consider cases for termination when any of the following special circumstances exist.

Special Circumstance Disenrollment

The EPAS Specialist will review cases that are non-routine in nature and involve circumstances that are specific to the participant involved. Examples of this type of disenrollment include:

- Self-employed participants who are unable to sustain the business' operations or receive income after a probationary period of 12 months
 - If the EPAS participant indicates more time is needed for the business to sustain its operations a time extension request order must be submitted to the EPAS Specialist 30 days before probationary period expires
- Participant misuses funds or Personal Assistants for anything other than for the services written on the approved Care Plan

- Participant no longer meets Medicaid program eligibility requirements
- Participant has demonstrated non-compliance with the agreed upon Care Plan and is unwilling to negotiate a Care Plan
- Participant does not consistently inform Service Coordinator of health, employment, safety, Medicaid status, address, phone number or Personal Assistant update or changes

If the EPAS Specialist determines that disenrollment is warranted, the EPAS Specialist will give the participant 30-days written notice of intent to terminate EPAS services. The Service Coordinator will also receive a copy of the termination notice. The notice will include the reason for termination, last date of service, information on how to contact the EPAS Specialist, and a Right to Fair Hearing Information form. Upon final termination, including the conclusion and final determination of any appeals, the EPAS Specialist will send written notice to the FMS Agency with instruction to discontinue payment of EPAS services and the date of termination.

Reenrollment

If the participant is disenrolled from the EPAS program for greater than 90 days, the applicant must complete a new application and complete the enrollment process as if they were a new applicant.

If the participant is disenrolled from the EPAS program for less than 90 days, the applicant's case will be reviewed to assure that participant has not had a significant change in health conditions. If there is a significant change in condition, a new MDS-HC must be completed by the EPAS Assessor. If there have been no significant changes in health conditions, the last MDS-HC assessment completed will be considered valid and the Service Coordinator will be required to submit the following documents to the EPAS Specialist:

- a Care Plan with new begin and end dates
- a new Participant Information Form
- a new Freedom of Choice Selection Form

The EPAS Specialist will then create new authorizations of service for the participant.

6-3 Retroactively Opening Cases or Making Payments

The EPAS Specialist will only open or authorize claims to be paid out 90 days retroactively consistent with the eligibility date as determined by the Division of Workforce Services (DWS). The participant's case may be open retroactively in the following circumstances:

- The participant remained working and met the minimum requirement of 40 hours a month and later paid their outstanding MWI premium or spend down amounts and became eligible for Medicaid once again.
- The participant was determined ineligible for Medicaid, for any reason, but remained working and met the minimum 40 hours a month requirement, and was retroactively opened by DWS to a status of Medicaid eligible. EPAS services could be retroactive consistent with the eligibility date as determined by the Division of Workforce Services (DWS).

7 Provider Reimbursement

7-1 Service Coordinating Agency, Financial Management Services Agency, EPAS Assessor, and Personal Care Agency Reimbursement

- A. A unique provider number is issued for each provider. When submitting claims for reimbursement, the provider must use their unique provider identification number, and the proper provider type number (68-Personal Services Agent or 54-Licensed Home Health Service, Category 21 Personal Care Services) associated with EPAS. Claims containing a provider number that is not associated with the proper program will be denied.
- B. Provider agencies will be reimbursed according to the specified reimbursement rate(s) found on the Coverage and Reimbursement Look-up Tool (<https://medicaid.utah.gov/coverage-and-reimbursement>).
- C. Provider agencies may only claim Medicaid reimbursements for services that are ordered by the EPAS Specialist and for which the provider has a current service authorization form. Service authorizations are valid for a maximum of 12 months, and must be reissued annually. The EPAS Specialist will supply the provider with a service authorization that contains the following information:
 - 1. The HCPCS billing code
 - 2. The amount and frequency of the service ordered
 - 3. The start and end date of the services
 - 4. EPAS Specialist signature and date

Claims must be consistent with the amount, frequency and dates authorized by the EPAS Specialist in order to be paid. Any services provided that exceed the amount or frequency authorized or for which there is not current service authorization form are not eligible for payment and will be denied. Any claims inaccurately paid will be recovered.

7-2 Self-Directed Personal Care Reimbursement

- A. To allow for accurate payroll processing, Personal Assistants are required to fill out all necessary paperwork designated by the EPAS participant's chosen Financial Management Services agency.
- B. Timesheets must be submitted in a timely manner by the EPAS participant to the Financial Management Service Agency according to the payroll calendar. EPAS participants are required to receive, sign and copy all employee(s) timesheets and submit them to the FMS agent twice a month. The participant is responsible to verify the accuracy of all hours billed by the employee(s).
- C. Personal Assistants may only claim reimbursement for services that are authorized by the EPAS Specialist on the Care Plan. Care Plans are valid for a maximum of one year, and must be reissued yearly. The EPAS participant's chosen Service Coordinator provides all Personal Assistants with a copy of the Participant's Care Plan that clearly identifies the EPAS service requested including:

1. The amount and frequency of the service ordered
2. The start and end date of the service
3. The category sub-task(s) and notes explaining the service to be rendered to the EPAS participant.

Timesheets/claims must be consistent with the amount, frequency and dates authorized by the EPAS Specialist in order to be paid by the Financial Management Services Agency. Any services that exceed the amount or frequency authorized on the Care Plan or for which there is not a current Care Plan are not eligible for payment and will be denied. Any claims inaccurately paid will be recovered.

- D. Personal Assistants are accountable for all terms, agreements, and responsibilities as defined in the Personal Assistant Employment Agreement Form, signed upon initial hire and the EPAS participant's annual review.

8 Employment Verification

8-1 Employed by Others

EPAS participants who are employed by others must work a minimum of 40 hours per month, and be gainfully employed in an integrated community setting making at least minimum wage. An integrated community setting is defined as a workplace or environment where there are persons with and without disabilities employed within the same company. Gainful employment is defined as an employment situation where the employee receives consistent work and payment of at least minimum wage from an employer. Employment must be reported monthly to the Service Coordinator and annually to the Department of Workforce Services.

1. Employment is verified through the Department of Workforce Services (DWS) annual Medicaid review, including earning statements as required by DWS. It is the responsibility of the EPAS participant to report employment to DWS and assure they remain Medicaid eligible in order to receive EPAS services. It is also the responsibility of the participant to submit earning statements monthly, not just annually, if they are affected by a Medicaid Work Incentive Premium (MWI) in which their income fluctuates.
2. Employment is also verified monthly by the Service Coordinator. Service Coordinators are responsible to contact the EPAS participant each month and gather a report of the amount of hours the EPAS participant has worked or will work that month. Service Coordinators are also responsible to verify employment hours by gathering the EPAS participant's earning statements for the previous month. In the case of participants who are self-employed, the Service Coordinator is responsible to collect documentation indicating the amount of hours worked, the type of work activity that was performed, as well as a financial statement indicating incoming and outgoing business expenses.
3. It is the EPAS participant's responsibility to assure they are meeting the minimum hour criteria of 40 hours per month (except for those who are self-employed) according to program requirements. Every EPAS participant must accurately report the number of hours worked each month to their Service Coordinator, as well as submitting monthly earning statements for the previous month to the Service Coordinator.

- i. If the EPAS participant does not meet the 40 hour per month minimum criteria they must report this to their Service Coordinator. Each case is subject to a hold, suspension, or disenrollment on a case by case basis if client is not meeting the minimum EPAS requirements.

8-2 Self-Employment

EPAS Participants may be self-employed. Self-employed participants must show that they are making a good faith effort to produce income and make a profit. Service Coordinators will be required to verify a participant's self-employment status. In order to verify self-employment status for the EPAS program, participants must provide the following documents at least annually:

1. Proof of business registration through the State of Utah or any applicable local municipalities. This may include a valid business license issued by either the State of Utah or a local municipality.
2. Submitted Federal Income Tax forms showing profit or loss from the business (e.g. IRS Form 1040 Schedule C) if applicable.

In addition to the documents listed above, at least two of the following documents must be provided monthly to the support coordinator:

- a) Log of hours worked with a description of activities
- b) Copy of Invoices or receipts sent or received during the month
- c) Copy of a lease on the business location (other than primary residence)
- d) Copy of Bank Statement showing payments to or from the business during the month

9 Adult Protective Services Reporting Requirements

Utah law (62A-3-305) mandates any person who has reason to believe that a vulnerable adult is being abused, neglected, or exploited must immediately notify Adult Protective Services or the nearest law enforcement office. Abuse may include physical abuse, emotional/verbal, caretaker neglect, self-neglect, or exploitation.

For definitions or more information about Adult Protective Services see:

<http://daas.utah.gov/adult-protective-services/>

10 Fair Hearings

10-1 EPAS Participant Fair Hearing Rights

The State Medicaid Agency provides an eligible individual applying for or receiving EPAS services an opportunity for a hearing upon written request, if the eligible individual is:

- Denied access to EPAS provider(s). If more than one provider is available to render the service(s).
or
- Experiencing a denial, reduction, suspension, or termination of EPAS services.

The process of a fair hearing will consist of the following activities:

1. An individual and the individual's legal representative as applicable, will receive a written Notice of Agency Action from the EPAS Specialist for any of the reasons listed above. The Notice of Agency Action delineates the individual's right to appeal the decision.
2. The aggrieved individual may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The Division of Medicaid and Health Financing may reinstate services for recipients or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than 10 calendar days after the date of action.
3. The individual is encouraged to utilize an informal dispute resolution process, directed by the EPAS Specialist, to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request be sent to the Department of Health, Division of Medicaid and Health Financing for a formal hearing and determination.

An informal dispute resolution process does not alter the requirements of the formal fair hearings process. The individual must still file a request for hearing and a request for continuation of services within the mandatory time frame established by the Division of Medicaid and Health Finance. An informal dispute resolution must occur prior to the deadline for filing the request for continuation of service and/or the request for formal hearing, or be conducted concurrent with the formal hearing process.

11 Security Breaches

11-1 Data Security and Privacy

Providers are expected to take steps to ensure that all personal information related to the individual being served is protected. This includes both Personal Health Information (PHI) as well as Personally Identifiable Information (PII). Providers should use appropriate administrative, technical and physical safeguards to preserve the integrity, confidentiality, and availability of PHI/PII that they create, receive, maintain or transmit. This includes using encrypted/secure email, fax, or other HIPAA compliant methods to transmit documents containing information about the individual being served. Providers shall ensure there is limited and controlled access to PHI/PII. In the performance of its services and operations, the provider shall make efforts to use, disclose and request only the minimum amount of PHI/PII considered reasonably necessary. The provider shall also identify and protect against reasonably anticipated threats to the security or integrity of the information, protect against reasonably anticipated, impermissible uses or disclosures; and ensure compliance by their workforce.

11-2 Breach Reporting/Data Loss

Providers must report to the EPAS Specialist in the Division of Medicaid and Health Financing (DMHF), either by email or telephone, any breach or loss of PHI/PII. This report should be completed not more than 24 hours

after the provider knows, or should have reasonably known about the breach. The provider must also submit a report in writing/by email to DFHP within 5 business days of the breach. The provider will also cooperate with any investigation of the breach or data loss.

12 References

Utah Administrative Code

R414-38, Personal Care Service

R432-725, Personal Care Agency Rule

42 CFR 440.167 Personal Care Services