Utah Department of
Health & Human Services
Integrated Healthcare

# Utah Medicaid Provider Manual

## Personal Care Services

**Division of Integrated Healthcare**

Updated September 2022

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# Introduction

The information in this manual represents personal care services available for members when medically necessary. Services may be more limited or expanded if medically appropriate, and more cost-effective services are available. This manual is designed to be used in conjunction with Section I: General Information and other provider manuals. Refer to the Utah Medicaid website at https://medicaid.utah.gov for additional resources.

This manual has two parts:

1. Personal Care Services (PCS), and
2. Employment-Related Personal Assistance Services (EPAS)

# PART 1 – TRADITIONAL PERSONAL CARE SERVICES

## 1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, noting the specific link that is not working and the page number for the link.

For general information regarding Utah Medicaid, refer to Section I: General Information, Chapter 1, General information.

### 1-1 Personal care services

The purpose of PCS is to provide supportive care to members in their place of residence, maximize independence, and prevent premature or inappropriate institutionalization. Supportive care offers a range of assistance services that enable persons with disabilities (cognitive or physical) and acute or chronic conditions to perform tasks associated with activities of daily living (ADLs) or instrumental activities of daily living (IADL).

PCS assists ADLs, IADLs, or other tasks that do not require direct intervention or supervision of a licensed healthcare professional. PCS assistance may be in the form

of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by themselves. These tasks may include, but are not limited to, those health care services which an unlicensed individual may perform without delegation by a healthcare provider per Utah Code Section 58-1-307.1 and Utah Admin. Code Subsection R156-31b-701a (1).

Agency staff must administer PCS as ordered by a physician and stated in the established care plan.

### 1-2 HCBS waiver personal care services

For PCS coverage under the Home and Community-Based Services (HCBS) waivers, see the Medicaid Home and Community-Based Waiver Services Manual for the specific waiver information.

## 2 Health plans

For more information about Managed Care Entities (MCE), refer to Section I: General Information, Chapter 2, Health plans.

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information, Chapter 2-1.2, Prepaid mental health plans, and the Rehabilitative Mental Health and Substance Use Disorder Services provider manual.

A list of ACOs and PMHPs with which Medicaid has a contract to provide health care services is found on the Medicaid website Managed Care: Accountable Care Organizations.

## 3 Provider participation and requirements

Refer to Section I: General Information, Chapter 3, Provider participation and requirements.

### 3-1 Electronic visit verification requirement

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, apply to all PCS provided under the Utah Medicaid State Plan or a 1915 (c) Home and Community-Based Waiver.

The Division of Integrated Healthcare collects and monitors EVV records from PCS providers.

Providers may select their own EVV service provider and must make records available to Medicaid for review. All systems must be compliant with the 21st Century Cures Act requirements, including:

1. Type of service performed;
2. Individual receiving the service;
3. Date of the service;
4. Location of service delivery;
5. Individual providing the service;
6. Time the service begins and ends; and
7. The date of creation of the electronic record.

For more information regarding EVV requirements, refer to Section I: General Information Chapter 11-9, Electronic visit verification requirements for home health and personal care services, and Utah Administrative Code R414.

## 4 Record keeping

Refer to Section I: General Information, Chapter 4, Record keeping.

## 5 Provider sanctions

Refer to Section I: General Information, Chapter 5, Provider sanctions.

## 6 Member eligibility

Refer to Section I: General Information, Chapter 6, Member eligibility, for information about verifying a member's eligibility, third party liability, ancillary providers, and

member identity protection requirements. Medicaid members not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

The provider's responsibility is to verify the member's eligibility before rendering services. For additional eligibility information, refer to Chapter 6, Member eligibility.

### 6-1 Personal care service eligibility requirements

PCS is available to members who meet the following conditions:

1. The member is non-bedbound.
2. The member is unable to independently perform two or more of the following personal care tasks:
    a) Self-administration of medications due to memory lapse.
    b) Toileting.
    c) Bathing or showering.
    d) Skincare.
    e) Ambulation.
    f) Personal grooming.
    g) Nutritional requirements, including meal planning, preparation, cleanup, and motivation to eat.
3. The member needs personal care to:
    a) Maintain the capacity to function, delay disease progression, prevent regression and complications, or
    b) Receive assistance while recovering from an acute condition.

## 7 Member responsibilities

For information on member responsibilities, including establishing eligibility and copayment requirements, refer to Section I: General Information, Chapter 7, Member responsibilities.

# 8 Programs and coverage

PCS are covered services provided by a home health agency or a personal care agency, as defined in Chapter 8-1, Definitions, and provided following Utah Medicaid policy.

## 8-1 Definitions

Definitions of terms used in other Medicaid programs are available in the Utah Medicaid provider manual, Section I: General Information. In addition, definitions specific to the content of this manual are provided below.

**Agency:** incorporates personal care agency and home health agency.

**Custodial care services:** Custodial care primarily assists ADLs, such as bathing, dressing, eating, and maintaining personal hygiene and safety.

**Certified nurse aide (CNA):** As stated in Utah Administrative Code Rule R432-45: A "Certified nurse aide" means any person who completes a nurse aide training and competency evaluation program (NATCEP) and passes the state certification examination. CNAs are required to practice within the parameter of their training and certifications.

**EVV:** Electronic visit verification

**Home health aide (HHA):** an individual who meets federal and State of Utah requirements of a home health aide, including those outlined in 42 CFR 484.80 and 440.70, Utah Administrative Code R414-14 and R432-700 (22)(23), and R432-725.

**Home health agency:** A public or private organization licensed by the Bureau of Health Facility Licensure and Certification under Utah Code Annotated, Title 26, Chapter 21 and is certified through the Centers for Medicare and Medicaid Services (CMS).

**Institution:** Institutions are residential facilities that assume total care of the admitted individuals.

**Licensed health care professional:** a professional licensed under Title 58, Occupational and Professional Licensing (Utah Code Annotated) by the Utah Department of Commerce who has the education and experience to assess and evaluate the member's health care needs.

**Personal care aide:** an individual who meets federal and State of Utah requirements for personal care aide services, including 42 CFR 440.167, 484.80(i) Administrative Code 414-38, 432-700-23 and R432-725-14.

**Personal care agency:** A care agency that consists of two or more individuals providing PCS on a visiting basis and is licensed under Utah Administration Code R432-725.

**Personal care assessment:** An assessment performed by a registered nurse on the initial visit or at the time of recertification that assesses:

1. The functional level of the member;
2. The adaptability of the member's place of residence to provide personal care services;
3. The capability of the member to participate in their care; and
4. To identify family support systems; or
5. Identify individuals who are willing to assume the appropriate level of responsibility to care for the member when they cannot care for themselves.

**Personal care services:** PCS provides supportive care to members in their place of residence, maximize independence, and prevent premature or inappropriate institutionalization. Supportive care offers a range of assistance services that enable persons with disabilities and acute or chronic conditions to accomplish tasks associated with ADLs and IADLs.

## 8-2 Personal care coverage requirements

### 8-2.1 Program access

Members must meet the following requirements to receive PCS:

1. A physician must prescribe the necessary PCS.
2. Only an agency may provide PCS.
3. Only a qualified personal care aide, a CNA, an HHA, a licensed practical nurse (LPN), or a registered nurse (RN) (performing only personal care level tasks) may provide PCS.
4. An RN must supervise the provision of PCS.
5. PCS is covered in a member's residence, not an institutional setting.
6. An RN must complete an initial personal care assessment to determine:
    a) The member's level of function;
    b) The adaptability of the member's place of residence to provide personal care services;
    c) The capability of the member to participate in their care; and
    d) To identify family support systems; or
    e) To identify individuals who are willing to assume the appropriate level of responsibility to care for the member when they cannot care for themselves.
7. An RN must complete a personal care assessment at recertification or sooner if warranted by a change in the member's condition.

### 8-2.2 Plan of care

Agencies must deliver PCS according to a written plan of care developed by agency staff, in consultation with the physician and their orders. The plan of care must include the following:

1. Diagnosis(es) supporting the medical need for PCS
2. Patient status:
    a) Mental and cognitive status
    b) Functional limitations
3. Service need:
    a) Frequency/duration of service
    b) Personal care tasks required
    c) Equipment required (if applicable)
    d) Medications
4. Discharge planning or referral
5. Other identified appropriate services

6. Identification of support systems

The parent/guardian is the primary caregiver for a minor child and is obligated to provide age-appropriate custodial care for a minor child with disabilities as they would for a developing child without disabilities.

The care plan must be signed by an RN and included in the agency's permanent record for the member. Changes to the care plan must be made in writing and signed by an RN or the person receiving the physician's orders. Verbal orders must be documented in writing on or before the following care plan review.

The certification period for each plan of care is 60 days. An RN must perform a new nursing assessment, and the agency must review and revise the plan of care as medically appropriate to fit the member's needs every 60 days. The care plan should always include consecutive dates from the previous plan unless there has been a break in service.

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

### 8-2.3 Supervision by a registered nurse

The RN must make a supervisory visit to the member's residence at least once every 60 days to ensure adequate care is provided according to the written plan of care. The visit may be made 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.

### 8-2.4 Record keeping

Agencies must maintain accurate and complete records per Utah Administrative Code R432-725-13 and Section I: General Information, Chapter 4-2, Record keeping and disclosure.

# 9 Non-covered services and limitations

The following represent limitations and non-covered services under PCS:

1. Nursing assessments are limited to one every 60 days.
    a) Nurses may perform assessments three (3) days before or two (2) days after the 60-day mark.
    b) Assessments conducted outside of this window require prior authorization.
2. Personal care aide services are limited to 60 hours per month.
3. Agencies may not furnish PCS for a member on the same day home health services or capitated home health services are delivered.
4. Services furnished by personal care aides are restricted to those outlined under the Division of Occupational and Professional Licensing (DOPL) Tasks an Unlicensed Individual May Perform Without Delegation.
5. PCS is non-covered if the member's needs exceed the level of care allowable for agencies as determined by policy.
6. An agency must refer a member to a licensed health care professional or an appropriate service provider who can safely meet the level of care required if the member's needs exceed that which is allowable under PCS.
7. PCS should not be confused with services that would more appropriately be provided by persons who provide chore services in the home. Examples of chore services that are not PCS include:
    a) Cleaning of floors and furniture in areas not occupied by the member.
    b) Laundry, other than that which is incidental to the care of the member.
    c) Care related to the member's pet(s).

# 10 Prior authorization

Personal care services reported under HCPCS code T1019 do not require prior authorization. Before performing any PCS, providers should verify whether or not a prior authorization is required using the Coverage and Reimbursement Code Lookup.

Medicaid does not provide retroactive authorization except in certain circumstances

detailed on the Section I: General Information provider manual, Chapter 10-3, Retroactive authorization.

# 11 Billing

Refer to Section I: General Information, Chapter 11, Billing Medicaid, for general information about billing instructions.

# 12 Coding

Refer to the Section I: General Information, Chapter 12, Coding, for information about coding, including diagnosis, procedure, and revenue codes.

For coverage and reimbursement information for specific procedure codes, see the Coverage and Reimbursement Code Lookup. Generally, the fees represented on the Coverage and Reimbursement Code Lookup are only for fee for service claims paid directly by Utah Medicaid using Utah Medicaid's fee schedule. This fee schedule does not account for any enhancement in fee schedule amounts (i.e., rural physician enhancements, rural dental enhancements, etc.).

## 12-1 Personal care service reportable codes

The following represents the typical service codes reported for PCS.

T1001 Initial and subsequent nurse assessments to establish a plan of care.

1. Agencies must perform an initial nurse assessment by an RN to assess the member's needs and functional level and establish the plan of care.
2. Reassessments must be performed every 60 days.

T1019 Personal care aide

1. Agency reporting of services with T1019 represents up to one hour per unit reported.

T1021 Home health aide, per visit

1. See the Utah Medicaid Provider Manual: Home Health Services and the Coverage and Reimbursement Lookup Tool for policy requirements related to code T1021.

### 12-2 Utilization modifiers

Medicaid provides enhancements to the reimbursement rate when travel distances to offer service are extensive. The enhancement is available only in rural counties where round-trip travel distances from the provider's base of operations are more than 50 miles. In addition, the member must reside in the same or an adjacent rural county as the provider.

Rural counties are counties other than Weber, Davis, Salt Lake, and Utah. Report the applicable service code with modifier "TN" to receive the rural home health travel enhancement.

For additional coverage information, refer to the Coverage and Reimbursement Code Lookup.

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

# PART 2 – EMPLOYMENT-RELATED PERSONAL ASSISTANT SERVICES

## 1 General information

### 1-1 General policy

Employment-related personal assistant services (EPAS) is an optional Utah Medicaid program authorized by Section 1905(a)(24) of the Social Security Act. Part 2 of the Personal Care Manual and addresses State Plan covered EPAS. For information related to traditional PCS, 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 and the Physician Services provider manuals.

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 PCS 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 MCE's.

## 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.

**OLTSS**

Office of Long Term Services and Supports.

**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 participant 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(s), creating and implementing care plans, and scheduling and coordinating with the EPAS assessor to complete periodic reassessments. Service coordinator provider qualifications include:

1. 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.
2. Possess a valid state or federal photo identification.
3. Have an applicable business license.
4. Pass a Utah criminal history and background check.
5. Have general liability/professional liability insurance.
6. Attend the mandatory EPAS service coordinator training provided by State Medicaid Agency staff and demonstrate required competencies for service coordination, protocols and procedures.
7. Complete the Utah Medicaid provider application.
8. Complete attachment A (located in the online PRISM enrollment system).
9. Complete and agree to provider responsibilities in attachment B (located in the online PRISM enrollment system).

## 2-2 Financial management services agency enrollment

If an EPAS participant chooses a non-agency individual to provide their PCS, a financial management services agency must 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:

1. Possess a business license.
2. Pass a Utah criminal history and background check.
3. Possess a valid state or federal photo identification.
4. Complete the Utah Medicaid provider application.
5. Complete attachment A (located in the online PRISM enrollment system).

## 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:

1. Must be a licensed clinical social worker (LCSW) or a registered nurse (RN).
2. Pass a Utah criminal history and background check.
3. Possess a valid state or federal photo identification.
4. Attend the mandatory EPAS assessor training provided by state Medicaid agency staff and demonstrate required competencies for completing assessments, protocol and procedures.
5. Complete the Utah Medicaid provider application.
6. Complete attachment A (located in the online PRISM enrollment system).

## 2-4 Personal care agency enrollment

EPAS may be delivered by a personal care agency licensed to provide PCS 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 PCS 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.

PCS may be delivered by an agency licensed to provide PCS 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:**

1. Must be at least 16 years of age.

2. Possess a valid state driver's license.
3. Possess automobile liability insurance if providing transportation services.
4. May not be the spouse of the EPAS participant.
5. May not be the parent of an EPAS participant under the age of 18.
6. Receive training on how to deliver EPAS services according to the authorized care plan by the EPAS participant and/or representative upon every care plan renewal.

# 3 Participant eligibility

## 3-1 Eligibility for EPAS services

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

1. Meet the SSI definition of disability.
2. Be gainfully employed in an integrated community setting making at least minimum wage.
    a) An integrated community setting is defined as a workplace or environment where there are persons with and without disabilities employed within the same company.
    b) Gainful employment is defined as an employment situation where the employee receives consistent work and payment of at least minimum wage from an employer.
3. Be employed and working for an employer at a minimum of 40 hours per month, or
    a) 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.
4. Be self-employed and able to demonstrate substantial income and specific work activity each month.
5. Need a personal assistant in order to remain employed.

The participant is not eligible if:

1. The participant is employed by the institutional setting in which they reside.

2. The participant is enrolled in a 1915(c) Home and Community-Based Waiver Program where PCS are provided as a component of covered waiver services.

**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, the eligibility lookup tool located at https://medicaid.utah.gov/eligibility, or call 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

### 4-1.1 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. Duplicate services at different times of the day from different providers are permitted; however, duplicate services at the same time of day are not allowed. Any instance where an individual requires two PAs at the same time of day to perform multiple tasks requires justification and prior authorization from the SMA.

1. ADLs include the following services:

   a) Mobility in bed
   b) Transferring
   c) Locomotion in and outside of home
   d) Dressing
   e) Eating
   f) Toileting (excludes assistance with enemas, suppositories, catheters and ostomy care or insertion of feminine hygiene products)
   g) Personal hygiene
   h) Bathing

2. IADLs include the following services:

   a) Meal preparation
   b) Ordinary housework
   c) Laundry
   d) Managing finances (includes assistance with simple budgeting, paying bills, and maintaining Medicaid eligibility spend downs or Medicaid work incentive requirements)
   e) Medications reminders and cueing (In compliance with the Utah Nurse Practice Act, personal assistants may administer medications, including the application of prescription ointments or creams).
   f) 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.
   g) Transportation: payment is rendered according to the time spent traveling from one destination to another. (EPAS does not provide medical transportation nor allow compensation for mileage, gas or time when the

participant is not in the vehicle with their personal assistant). Authorized uses of travel include:

i. Accompanying the individual to and from public transportation for work.
   1 Time is authorized for when the personal assistant is with the participant.
ii. Transporting the participant to and from work.
iii. Time is authorized for when the personal assistant is with the participant in the vehicle.
   Transporting the individual to go shopping for items described in Item 6 above.
iv. 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.
v. Transporting the individual to and from the pharmacy to pick up or drop off prescription medication orders.
vi. Transporting the individual to and from the bank/financial institution to fulfill services described above in item 4.

### 4-1.2 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.

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.

### 4-1.3 Service coordination services

As part of the care planning process, the service coordinator is responsible to review the results of the MDSHC assessment and the MDS-HC criteria scoring form. The service coordinator is responsible for developing a written individualized care plan.

The plan must include:

1. The name, date of birth, and Medicaid ID of the individual.
2. Employment data.
3. Care plan type selection of initial, annual, or change in information.
4. Billing or HCPCS codes for service coordination, financial management services agency, and personal attendant services.
5. Name of chosen service providers.
6. The recommended amount and frequency of services. Explained in both weekly and monthly hours.
7. The care plan’s beginning and end date of services.

8. Other employment or community supports being utilized by the individual.
9. The basis for the need of ADL or IADL assistance, including MDS-HC impairment score data.
10. Signatures from the participant or representative, service coordinator, and State Medicaid Agency.

### 4-1.4 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.
   a) It is possible to complete several assessments within a one-year time frame due to possible changes in health status or circumstances 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.
   a) For example: If a participant's new care plan begin date was Jan 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. 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 Jan 13, 2015; however, upon developing the participant's annual care plan, the care plan must start on the first of the month or Jan 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 PCS. Financial management service agencies will receive a separate authorization/ budget for each EPAS participant.

### 4-2 Non-covered services

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

## 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 | Rate (unit/hour) |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| T1028 | Home assessment, determination of PT's needs | 68 | Per encounter | Rate can be found on Coverage and Reimbursement Look-Up Tool* |
| S5125 | Self-directed service attendant care | 54 | 15 min = 1 unit | Self-directed service attendant care is 61% of the maximal allowable rate (MAR) for traditional attendant care* |
| S5125 | Traditional attendant care services | 54 | 15 min = 1 unit | Rate can be found on Coverage and Reimbursement Look-Up Tool* |
| S5125 TU | Self-directed service attendant care (overtime) | 54/68 | 15 min = 1 unit | Modifies base payment to 150% of submitted charge |
| T2040 | Financial management services, self-directed | 68 | 1 unit allowed per month, per member | Rate can be found on Coverage and Reimbursement Look-Up Tool* |
| T2024 | Service coordination, service assessment/plan of care development | 68 | 15 min =1 unit | Rate can be found on Coverage and Reimbursement Look-Up Tool* |

* Utah HCPCS 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:

1. 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 to the EPAS specialist, a referral from the EPAS specialist to the chosen EPAS assessor and service coordinator is made.
2. 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.
3. 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.
4. 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 PCS. 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.
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 may include:

1. The participant is hospitalized or admitted to a nursing facility and is unable to remain working. If the participant remains in the hospital or nursing facility longer than 60 days without continuing employment, the participant will be disenrolled from the program.
    a) The participant is unable to be contacted.
        i. If the participant is unable to be contacted by the service coordinator for more than 30 days their case will be reviewed for possible disenrollment.
    b) The participant is on vacation.
        i. If the participant is on vacation for more than 30 days their case will be reviewed for possible disenrollment.
2. The participant goes on maternity leave.
    a) If the participant is receiving personal time or annual pay while away on maternity leave, services may continue uninterrupted. However, if the participant is not receiving income from their place of employment during maternity leave, services will be suspended until they return to work.
3. The participant did not pay their Medicaid work incentive (MWI) premium or spend down for the month.
    a) 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's case is closed by the Division of Workforce Services (DWS) for outstanding premium or spenddown amounts the participant will be disenrolled.
4. The participant does not meet the minimum of 40 work hours per month criteria or fails to submit monthly employment information.
    a) If a 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 to work and are able to continue performing the 40-hour minimum per month. An absence longer than 60 days will be reviewed for possible disenrollment.

b) If the participant is consistently not meeting the 40-hour minimum work hour criteria, their case will be reviewed for possible disenrollment. Each situation will be evaluated on a case by case basis by the EPAS specialist.
c) If the participant has personal, sick, or annual time in which they may still receive income when they are not working, their services may continue uninterrupted.
d) Self-employed participants who fail to submit their monthly income financial statements, ledgers, work activity logs, or federal tax returns for 60 days or more will be reviewed for possible disenrollment. All work hours must be accounted for in relation to the participant's business. If an activity does not have the potential to produce a new consumer or revenue, it is not considered to be work related.
e) Participants who are employed by others and fail to submit at least one earning statement per month to their chosen service coordinator, for 60 days or more, will be reviewed for possible disenrollment.

## 6-2 Disenrollment, termination, and reenrollment of EPAS services

### 6-2.1 Disenrollment

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. The EPAS specialist will review cases that are non-routine in nature and involve circumstances that are specific to the participant involved. In addition, the EPAS specialist will consider cases for termination when any of the following circumstances exist.

1. The participant no longer meets Medicaid program eligibility requirements and was determined to be ineligible for Medicaid by DWS (e.g., moved out of state,

participant did not submit Medicaid review documentation, outstanding premium or spenddowns, etc.)

2. The participant's employment has been terminated for any reason (quit, fired, laid off).
3. The participant has 30 days from their last day of work to regain employment 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 regain employment before the case is terminated.
4. Self-employed participants who are unable to sustain business operations or receive income after a period of 12 months.
5. Participant is noncompliant with the authorized care plan and/or program policies and regulations.
6. Participant has not utilized EPAS services for 60 days or more (i.e., did not hire a personal assistant).
7. Fraud and/or misuse of Medicaid funds.

The service coordinator or EPAS specialist may initiate disenrollment. The EPAS specialist will review all recommended disenrollments that are submitted by the service coordinator. Should the disenrollment request be approved, Medicaid will provide the participant with a notice of decision. The notice will include the reason for termination, last date of service, information on how to contact the EPAS specialist, and information on how the participant may exercise their right to an appeal if they disagree with the decision. Upon final termination, including the final determination of any appeals, the EPAS specialist will send written notice to the participant's provider agencies with a date of termination.

### 6-2.2 Reenrollment

If the participant is disenrolled from the EPAS program for more than 90 days, the participant 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:

1. A care plan with new begin and end dates.
2. A new participant information form.
3. A new freedom of choice selection form.
4. A new SAS employer/employee agreements.

The EPAS specialist will then create 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 circumstance:

1. The participant was determined ineligible for Medicaid, for any reason, but remained working and continued to meet EPAS eligibility criteria (i.e., working 40 hours per month), and was retroactively opened by DWS to a status of Medicaid eligible. EPAS services may 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

1. 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-PCS) associated with EPAS. Claims containing a provider number that is not associated with the proper program will be denied.

2. Provider agencies will be reimbursed according to the specified reimbursement rate(s) found on the Coverage and Reimbursement Look-Up Tool at https://medicaid.utah.gov/coverage-and-reimbursement.

3. 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.

4. Financial management services reimbursement
   Reimbursement for self-administered services includes reimbursement for all mandatory employer payroll taxes, and workman's compensation insurance premiums. These costs should be paid in addition to the self-administered service rate established between the waiver participant and the employee. For example, if a waiver participant negotiates an hourly wage of $10 per hour with their self-administered services employee, mandatory employer burden costs (e.g., Social Security and Medicare taxes, Federal Unemployment Taxes, and Worker's Compensation Insurance premiums) are paid in addition to the $10 per hour wage. The employee's income tax withholding should be deducted from the negotiated wage.

## 7-2 Self-directed personal care reimbursement

1. 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. The personal assistant(s) will not be paid for any dates of service prior to the FMS agency paperwork being completed.
2. 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 timesheets and submit them to the FMS agency. The participant is responsible to verify the accuracy of all hours billed by the employee(s).
3. 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 annually. The EPAS participant must provide all personal assistants with a copy of the authorized care plan that clearly identifies the EPAS service requested including:

   a) The amount and frequency of the service ordered.

   b) The start and end date of the service.

   c) 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 an authorized care plan, are not eligible for payment and will be denied. Any claims inaccurately paid will be recovered.
4. Personal assistants are accountable for all terms, agreements, and responsibilities as defined in the employer/employee agreement form, signed upon initial hire and the EPAS participant's annual review.
5. Inappropriate personal assistant use will be reviewed by the SMA and may result in disciplinary action. Suspected misuse of personal assistant services can be reported to the Utah Office of Inspector General for review and possible investigation.

# 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 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 number 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.

a) 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 participant 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:

1. Log of hours worked with a description of activities.
2. Copy of invoices or receipts sent or received during the month.
3. Copy of a lease on the business location (other than primary residence).
4. 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:

1. Denied access to EPAS provider(s). If more than one provider is available to render the service(s),
   OR
2. 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 against 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 Integrated Healthcare 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 and Human Services, Division of Integrated Healthcare for a formal hearing and determination.

An informal dispute resolution process does not alter the requirements of the formal fair hearing 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 Integrated Healthcare. 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 Integrated Healthcare (DIH), 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, PCS

R432-725, Personal Care Agency Rule

42 CFR 440.167 PCS