192.2000. Division of aging created — duties — inspectors of nursing homes, training and continuing education requirements — promulgation of rules, procedure — dementia-specific training requirements established. — 1. The "Division of Aging" is hereby transferred from the department of social services to the department of health and senior services by a type I transfer as defined in the Omnibus State Reorganization Act of 1974. The department shall aid and assist the elderly and low-income disabled adults living in the state of Missouri to secure and maintain maximum economic and personal independence and dignity. The department shall regulate adult long-term care facilities pursuant to the laws of this state and rules and regulations of federal and state agencies, to safeguard the lives and rights of residents in these facilities.

2. In addition to its duties and responsibilities enumerated pursuant to other provisions of law, the department shall:

(1) Serve as advocate for the elderly by promoting a comprehensive, coordinated service program through administration of Older Americans Act (OAA) programs (Title III) P.L. 89-73, (42 U.S.C. Section 3001, et seq.), as amended;

(2) Assure that an information and referral system is developed and operated for the elderly, including information on home and community based services;

(3) Provide technical assistance, planning and training to local area agencies on aging;

(4) Contract with the federal government to conduct surveys of long-term care facilities certified for participation in the Title XVIII program;

(5) Conduct medical review (inspections of care) activities such as utilization reviews, independent professional reviews, and periodic medical reviews to determine medical and social needs for the purpose of eligibility for Title XIX, and for level of care determination;

(6) Certify long-term care facilities for participation in the Title XIX program;

(7) Conduct a survey and review of compliance with P.L. 96-566 Sec. 505(d) for Supplemental Security Income recipients in long-term care facilities and serve as the
liaison between the Social Security Administration and the department of health and senior services concerning Supplemental Security Income beneficiaries;

(8) Review plans of proposed long-term care facilities before they are constructed to determine if they meet applicable state and federal construction standards;

(9) Provide consultation to long-term care facilities in all areas governed by state and federal regulations;

(10) Serve as the central state agency with primary responsibility for the planning, coordination, development, and evaluation of policy, programs, and services for elderly persons in Missouri consistent with the provisions of subsection 1 of this section and serve as the designated state unit on aging, as defined in the Older Americans Act of 1965;

(11) Develop long-range state plans for programs, services, and activities for elderly and handicapped persons. State plans should be revised annually and should be based on area agency on aging plans, statewide priorities, and state and federal requirements;

(12) Receive and disburse all federal and state funds allocated to the division and solicit, accept, and administer grants, including federal grants, or gifts made to the division or to the state for the benefit of elderly persons in this state;

(13) Serve, within government and in the state at large, as an advocate for elderly persons by holding hearings and conducting studies or investigations concerning matters affecting the health, safety, and welfare of elderly persons and by assisting elderly persons to assure their rights to apply for and receive services and to be given fair hearings when such services are denied;

(14) Conduct research and other appropriate activities to determine the needs of elderly persons in this state, including, but not limited to, their needs for social and health services, and to determine what existing services and facilities, private and public, are available to elderly persons to meet those needs;

(15) Maintain and serve as a clearinghouse for up-to-date information and technical assistance related to the needs and interests of elderly persons and persons with Alzheimer's disease or related dementias, including information on the home and community based services program, dementia-specific training materials and dementia-specific trainers. Such dementia-specific information and technical assistance shall be maintained and provided in consultation with agencies, organizations and/or institutions of higher learning with expertise in dementia care;

(16) Provide area agencies on aging with assistance in applying for federal, state, and private grants and identifying new funding sources;

(17) Determine area agencies on aging annual allocations for Title XX and Title III of the Older Americans Act expenditures;
(18) Provide transportation services, home-delivered and congregate meals, in-home services, counseling and other services to the elderly and low-income handicapped adults as designated in the Social Services Block Grant Report, through contract with other agencies, and shall monitor such agencies to ensure that services contracted for are delivered and meet standards of quality set by the division;

(19) Monitor the process pursuant to the federal Patient Self-determination Act, 42 U.S.C. Section 1396a (w), in long-term care facilities by which information is provided to patients concerning durable powers of attorney and living wills.

3. The department may withdraw designation of an area agency on aging only when it can be shown the federal or state laws or rules have not been complied with, state or federal funds are not being expended for the purposes for which they were intended, or the elderly are not receiving appropriate services within available resources, and after consultation with the director of the area agency on aging and the area agency board. Withdrawal of any particular program of services may be appealed to the director of the department of health and senior services and the governor. In the event that the division withdraws the area agency on aging designation in accordance with the Older Americans Act, the department shall administer the services to clients previously performed by the area agency on aging until a new area agency on aging is designated.

4. Any person hired by the department of health and senior services after August 13, 1988, to conduct or supervise inspections, surveys or investigations pursuant to chapter 198 shall complete at least one hundred hours of basic orientation regarding the inspection process and applicable rules and statutes during the first six months of employment. Any such person shall annually, on the anniversary date of employment, present to the department evidence of having completed at least twenty hours of continuing education in at least two of the following categories: communication techniques, skills development, resident care, or policy update. The department of health and senior services shall by rule describe the curriculum and structure of such continuing education.

5. The department may issue and promulgate rules to enforce, implement and effectuate the powers and duties established in this section and sections 198.070 and 198.090 and sections 192.2400 and 192.2475 to 192.2500. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2001, shall be invalid and void.
6. Home and community based services is a program, operated and coordinated by the department of health and senior services, which informs individuals of the variety of care options available to them when they may need long-term care.

7. The division shall maintain minimum dementia-specific training requirements for employees involved in the delivery of care to persons with Alzheimer’s disease or related dementias who are employed by skilled nursing facilities, intermediate care facilities, residential care facilities*, agencies providing in-home care services authorized by the division of aging, adult day-care programs, independent contractors providing direct care to persons with Alzheimer's disease or related dementias and the division of aging. Such training shall be incorporated into new employee orientation and ongoing in-service curricula for all employees involved in the care of persons with dementia. The department of health and senior services shall maintain minimum dementia-specific training requirements for employees involved in the delivery of care to persons with Alzheimer's disease or related dementias who are employed by home health and hospice agencies licensed by chapter 197. Such training shall be incorporated into the home health and hospice agency's new employee orientation and ongoing in-service curricula for all employees involved in the care of persons with dementia. The dementia training need not require additional hours of orientation or ongoing in-service. Training shall include at a minimum, the following:

   (1) For employees providing direct care to persons with Alzheimer's disease or related dementias, the training shall include an overview of Alzheimer's disease and related dementias, communicating with persons with dementia, behavior management, promoting independence in activities of daily living, and understanding and dealing with family issues;

   (2) For other employees who do not provide direct care for, but may have daily contact with, persons with Alzheimer's disease or related dementias, the training shall include an overview of dementias and communicating with persons with dementia.

As used in this subsection, the term "employee" includes persons hired as independent contractors. The training requirements of this subsection shall not be construed as superceding any other laws or rules regarding dementia-specific training.

Transferred 2014; formerly 660.050

*Revisor's note: The term "residential care facilities" may include "assisted living facilities", see section 198.005 regarding changes to name reference.

< end of effective 28 Aug 2014 >

use this link to bookmark section 192.2000

In accordance with Section 3.090, the language of statutory sections enacted during a legislative session are updated and available on this website on the effective date of such enacted statutory section.

Other Information

Tables and Forms  Sections with Definitions  Repealers / Transfers  MOGA

© Missouri Legislature, all rights reserved.

Site errors / suggestions - webmaster@LR.mo.gov

Over 27,133,400 page views.
Title XII PUBLIC HEALTH AND WELFARE

Chapter 192

192.2475. Report of abuse or neglect of in-home services or home health agency client, duty — penalty — contents of report — investigation, procedure — confidentiality of report — immunity — retaliation prohibited, penalty — employee disqualification list — safe at home evaluations, procedure. — 1. When any adult day care worker; chiropractor; Christian Science practitioner; coroner; dentist; embalmer; emergency medical technician; employee of the departments of social services, mental health, or health and senior services; employee of a local area agency on aging or an organized area agency on aging program; firefighter; first responder, as defined in section 192.2405; funeral director; home health agency or home health agency employee; hospital and clinic personnel engaged in examination, care, or treatment of persons; in-home services owner, provider, operator, or employee; law enforcement officer; long-term care facility administrator or employee; medical examiner; medical resident or intern; mental health professional; minister; nurse; nurse practitioner; optometrist; other health practitioner; peace officer; pharmacist; physical therapist; physician; physician’s assistant; podiatrist; probation or parole officer; psychologist; or social worker has reasonable cause to believe that an in-home services client has been abused or neglected, as a result of in-home services, he or she shall immediately report or cause a report to be made to the department. If the report is made by a physician of the in-home services client, the department shall maintain contact with the physician regarding the progress of the investigation.

2. Any person required in subsection 1 of this section to report or cause a report to be made to the department who fails to do so within a reasonable time after the act of abuse or neglect is guilty of a class A misdemeanor.

3. The report shall contain the names and addresses of the in-home services provider agency, the in-home services employee, the in-home services client, the home health agency, the home health agency employee, information regarding the nature of the abuse or neglect, the name of the complainant, and any other information which might be helpful in an investigation.
4. In addition to those persons required to report under subsection 1 of this section, any other person having reasonable cause to believe that an in-home services client or home health patient has been abused or neglected by an in-home services employee or home health agency employee may report such information to the department.

5. If the investigation indicates possible abuse or neglect of an in-home services client or home health patient, the investigator shall refer the complaint together with his or her report to the department director or his or her designee for appropriate action. If, during the investigation or at its completion, the department has reasonable cause to believe that immediate action is necessary to protect the in-home services client or home health patient from abuse or neglect, the department or the local prosecuting attorney may, or the attorney general upon request of the department shall, file a petition for temporary care and protection of the in-home services client or home health patient in a circuit court of competent jurisdiction. The circuit court in which the petition is filed shall have equitable jurisdiction to issue an ex parte order granting the department authority for the temporary care and protection of the in-home services client or home health patient, for a period not to exceed thirty days.

6. Reports shall be confidential, as provided under section 192.2500.

7. Anyone, except any person who has abused or neglected an in-home services client or home health patient, who makes a report pursuant to this section or who testifies in any administrative or judicial proceeding arising from the report shall be immune from any civil or criminal liability for making such a report or for testifying except for liability for perjury, unless such person acted negligently, recklessly, in bad faith, or with malicious purpose.

8. Within five working days after a report required to be made under this section is received, the person making the report shall be notified in writing of its receipt and of the initiation of the investigation.

9. No person who directs or exercises any authority in an in-home services provider agency or home health agency shall harass, dismiss or retaliate against an in-home services client or home health patient, or an in-home services employee or a home health agency employee because he or she or any member of his or her family has made a report of any violation or suspected violation of laws, standards or regulations applying to the in-home services provider agency or home health agency or any in-home services employee or home health agency employee which he or she has reasonable cause to believe has been committed or has occurred.

10. Any person who abuses or neglects an in-home services client or home health patient is subject to criminal prosecution under section 565.184. If such person is an in-home services employee and has been found guilty by a court, and if the supervising in-home services provider willfully and knowingly failed to report known abuse by such
employee to the department, the supervising in-home services provider may be subject to administrative penalties of one thousand dollars per violation to be collected by the department and the money received therefor shall be paid to the director of revenue and deposited in the state treasury to the credit of the general revenue fund. Any in-home services provider which has had administrative penalties imposed by the department or which has had its contract terminated may seek an administrative review of the department’s action pursuant to chapter 621. Any decision of the administrative hearing commission may be appealed to the circuit court in the county where the violation occurred for a trial de novo. For purposes of this subsection, the term “violation” means a determination of guilt by a court.

11. The department shall establish a quality assurance and supervision process for clients that requires an in-home services provider agency to conduct random visits to verify compliance with program standards and verify the accuracy of records kept by an in-home services employee.

12. The department shall maintain the employee disqualification list and place on the employee disqualification list the names of any persons who have been finally determined by the department, pursuant to section 192.2490, to have recklessly, knowingly or purposely abused or neglected an in-home services client or home health patient while employed by an in-home services provider agency or home health agency. For purposes of this section only, "knowingly" and "recklessly" shall have the meanings that are ascribed to them in this section. A person acts “knowingly” with respect to the person’s conduct when a reasonable person should be aware of the result caused by his or her conduct. A person acts “recklessly” when the person consciously disregards a substantial and unjustifiable risk that the person’s conduct will result in serious physical injury and such disregard constitutes a gross deviation from the standard of care that a reasonable person would exercise in the situation.

13. At the time a client has been assessed to determine the level of care as required by rule and is eligible for in-home services, the department shall conduct a safe at home evaluation to determine the client’s physical, mental, and environmental capacity. The department shall develop the safe at home evaluation tool by rule in accordance with chapter 536. The purpose of the safe at home evaluation is to assure that each client has the appropriate level of services and professionals involved in the client’s care. The plan of service or care for each in-home services client shall be authorized by a nurse. The department may authorize the licensed in-home services nurse, in lieu of the department nurse, to conduct the assessment of the client’s condition and to establish a plan of services or care. The department may use the expertise, services, or programs of other departments and agencies on a case-by-case basis to establish the plan of service or care. The department may, as indicated by the safe at home evaluation, refer any client to
a mental health professional, as defined in 9 CSR 30- 4.030, for evaluation and treatment as necessary.

14. Authorized nurse visits shall occur at least twice annually to assess the client and the client’s plan of services. The provider nurse shall report the results of his or her visits to the client’s case manager. If the provider nurse believes that the plan of service requires alteration, the department shall be notified and the department shall make a client evaluation. All authorized nurse visits shall be reimbursed to the in-home services provider. All authorized nurse visits shall be reimbursed outside of the nursing home cap for in-home services clients whose services have reached one hundred percent of the average statewide charge for care and treatment in an intermediate care facility, provided that the services have been preauthorized by the department.

15. All in-home services clients shall be advised of their rights by the department or the department’s designee at the initial evaluation. The rights shall include, but not be limited to, the right to call the department for any reason, including dissatisfaction with the provider or services. The department may contract for services relating to receiving such complaints. The department shall establish a process to receive such nonabuse and neglect calls other than the elder abuse and neglect hotline.

16. Subject to appropriations, all nurse visits authorized in sections 192.2400 to 192.2475 shall be reimbursed to the in-home services provider agency.


Effective 1-01-17
Transferred 2014; formerly 660.300

< end of effective 28 Aug 2016 >

use this link to bookmark section 192.2475

- All entries

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective</strong></td>
<td><strong>End</strong></td>
</tr>
<tr>
<td>192.2475</td>
<td>8/28/2016</td>
</tr>
<tr>
<td>192.2475</td>
<td>1/1/2017 8/28/2016</td>
</tr>
<tr>
<td>192.2475</td>
<td>8/28/2016 1/1/2017</td>
</tr>
</tbody>
</table>
In accordance with Section 3.090, the language of statutory sections enacted during a legislative session are updated and available on this website on the effective date of such enacted statutory section.

<table>
<thead>
<tr>
<th>Other Information</th>
<th>Tables and Forms</th>
<th>Sections with Definitions</th>
<th>Repealers / Transfers</th>
<th>MOGA</th>
</tr>
</thead>
</table>

© Missouri Legislature, all rights reserved. Site errors / suggestions - webmaster@LR.mo.gov

Over 27,133,400 page views.

00:31:42

22
Title XII PUBLIC HEALTH AND WELFARE

Chapter 192

192.2490. Employee disqualification list, notification of placement, contents — challenge of allegation, procedure — hearing, procedure — appeal — removal of name from list — list provided to whom — prohibition of employment. — 1. After an investigation and a determination has been made to place a person’s name on the employee disqualification list, that person shall be notified in writing mailed to his or her last known address that:

(1) An allegation has been made against the person, the substance of the allegation and that an investigation has been conducted which tends to substantiate the allegation;

(2) The person’s name will be included in the employee disqualification list of the department;

(3) The consequences of being so listed including the length of time to be listed; and

(4) The person’s rights and the procedure to challenge the allegation.

2. If no reply has been received within thirty days of mailing the notice, the department may include the name of such person on its list. The length of time the person’s name shall appear on the employee disqualification list shall be determined by the director or the director’s designee, based upon the criteria contained in subsection 9 of this section.

3. If the person so notified wishes to challenge the allegation, such person may file an application for a hearing with the department. The department shall grant the application within thirty days after receipt by the department and set the matter for hearing, or the department shall notify the applicant that, after review, the allegation has been held to be unfounded and the applicant’s name will not be listed.

4. If a person’s name is included on the employee disqualification list without the department providing notice as required under subsection 1 of this section, such person may file a request with the department for removal of the name or for a hearing. Within thirty days after receipt of the request, the department shall either remove the name from the list or grant a hearing and set a date therefor.
5. Any hearing shall be conducted in the county of the person’s residence by the director of the department or the director’s designee. The provisions of chapter 536 for a contested case except those provisions or amendments which are in conflict with this section shall apply to and govern the proceedings contained in this section and the rights and duties of the parties involved. The person appealing such an action shall be entitled to present evidence, pursuant to the provisions of chapter 536, relevant to the allegations.

6. Upon the record made at the hearing, the director of the department or the director’s designee shall determine all questions presented and shall determine whether the person shall be listed on the employee disqualification list. The director of the department or the director’s designee shall clearly state the reasons for his or her decision and shall include a statement of findings of fact and conclusions of law pertinent to the questions in issue.

7. A person aggrieved by the decision following the hearing shall be informed of his or her right to seek judicial review as provided under chapter 536. If the person fails to appeal the director’s findings, those findings shall constitute a final determination that the person shall be placed on the employee disqualification list.

8. A decision by the director shall be inadmissible in any civil action brought against a facility or the in-home services provider agency and arising out of the facts and circumstances which brought about the employment disqualification proceeding, unless the civil action is brought against the facility or the in-home services provider agency by the department of health and senior services or one of its divisions.

9. The length of time the person’s name shall appear on the employee disqualification list shall be determined by the director of the department of health and senior services or the director’s designee, based upon the following:

   (1) Whether the person acted recklessly or knowingly, as defined in chapter 562;

   (2) The degree of the physical, sexual, or emotional injury or harm; or the degree of the imminent danger to the health, safety or welfare of a resident or in-home services client;

   (3) The degree of misappropriation of the property or funds, or falsification of any documents for service delivery of an in-home services client;

   (4) Whether the person has previously been listed on the employee disqualification list;

   (5) Any mitigating circumstances;

   (6) Any aggravating circumstances; and

   (7) Whether alternative sanctions resulting in conditions of continued employment are appropriate in lieu of placing a person’s name on the employee disqualification list. Such conditions of employment may include, but are not limited to, additional training and employee counseling. Conditional employment shall terminate upon the expiration of the
designated length of time and the person's submitting documentation which fulfills the department of health and senior services' requirements.

10. The removal of any person's name from the list under this section shall not prevent the director from keeping records of all acts finally determined to have occurred under this section.

11. The department shall provide the list maintained pursuant to this section to other state departments upon request and to any person, corporation, organization, or association who:

(1) Is licensed as an operator under chapter 198;

(2) Provides in-home services under contract with the department of social services or its divisions;

(3) Employs health care providers as defined in section 376.1350 for temporary or intermittent placement in health care facilities;

(4) Is approved by the department to issue certificates for nursing assistants training;

(5) Is an entity licensed under chapter 197;

(6) Is a recognized school of nursing, medicine, or other health profession for the purpose of determining whether students scheduled to participate in clinical rotations with entities described in subdivision (1), (2), or (5) of this subsection are included in the employee disqualification list; or

(7) Is a consumer reporting agency regulated by the federal Fair Credit Reporting Act that conducts employee background checks on behalf of entities listed in this subsection. Such a consumer reporting agency shall conduct the employee disqualification list check only upon the initiative or request of an entity described in this subsection when the entity is fulfilling its duties required under this section.

The information shall be disclosed only to the requesting entity. The department shall inform any person listed above who inquires of the department whether or not a particular name is on the list. The department may require that the request be made in writing. No person, corporation, organization, or association who is entitled to access the employee disqualification list may disclose the information to any person, corporation, organization, or association who is not entitled to access the list. Any person, corporation, organization, or association who is entitled to access the employee disqualification list who discloses the information to any person, corporation, organization, or association who is not entitled to access the list shall be guilty of an infraction.
12. No person, corporation, organization, or association who received the employee disqualification list under subdivisions (1) to (7) of subsection 11 of this section shall knowingly employ any person who is on the employee disqualification list. Any person, corporation, organization, or association who received the employee disqualification list under subdivisions (1) to (7) of subsection 11 of this section, or any person responsible for providing health care service, who declines to employ or terminates a person whose name is listed in this section shall be immune from suit by that person or anyone else acting for or in behalf of that person for the failure to employ or for the termination of the person whose name is listed on the employee disqualification list.

13. Any employer or vendor as defined in sections 197.250, 197.400, 198.006, 208.900, or 192.2400 required to deny employment to an applicant or to discharge an employee, provisional or otherwise, as a result of information obtained through any portion of the background screening and employment eligibility determination process under section 210.903, or subsequent, periodic screenings, shall not be liable in any action brought by the applicant or employee relating to discharge where the employer is required by law to terminate the employee, provisional or otherwise, and shall not be charged for unemployment insurance benefits based on wages paid to the employee for work prior to the date of discharge, pursuant to section 288.100, if the employer terminated the employee because the employee:

   (1) Has been found guilty, pled guilty or nolo contendere in this state or any other state of a crime as listed in subsection 6 of section 192.2495;

   (2) Was placed on the employee disqualification list under this section after the date of hire;

   (3) Was placed on the employee disqualification registry maintained by the department of mental health after the date of hire;

   (4) Has a disqualifying finding under this section, section 192.2495, or is on any of the background check lists in the family care safety registry under sections 210.900 to 210.936; or

   (5) Was denied a good cause waiver as provided for in subsection 10 of section 192.2495.

14. Any person who has been listed on the employee disqualification list may request that the director remove his or her name from the employee disqualification list. The request shall be written and may not be made more than once every twelve months. The request will be granted by the director upon a clear showing, by written submission only, that the person will not commit additional acts of abuse, neglect, misappropriation of the property or funds, or the falsification of any documents of service delivery to an in-home services client. The director may make conditional the removal of a person's name from
the list on any terms that the director deems appropriate, and failure to comply with such terms may result in the person’s name being relisted. The director’s determination of whether to remove the person’s name from the list is not subject to appeal.


Transferred 2014; formerly 660.315

< end of effective 28 Aug 2016 >

use this link to bookmark section 192.2490

- All entries

<table>
<thead>
<tr>
<th></th>
<th>Effective</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>192.2490</td>
<td>8/28/2016</td>
<td></td>
</tr>
</tbody>
</table>

In accordance with Section 3.090, the language of statutory sections enacted during a legislative session are updated and available on this website on the effective date of such enacted statutory section.

Other Information

<table>
<thead>
<tr>
<th>Tables and Forms</th>
<th>Sections with Definitions</th>
<th>Repealers / Transfers</th>
<th>MOGA</th>
</tr>
</thead>
</table>

© Missouri Legislature, all rights reserved. Site errors / suggestions - webmaster@LR.mo.gov

Over 27,133,400 page views.

00:31:52
192.2495. Criminal background checks of employees, required when — persons with criminal history not to be hired, when, penalty — failure to disclose, penalty — improper hirings, penalty — definitions — rules to waive hiring restrictions. — 1. For the purposes of this section, the term "provider" means any person, corporation or association who:

(1) Is licensed as an operator pursuant to chapter 198;

(2) Provides in-home services under contract with the department of social services or its divisions;

(3) Employs health care providers as defined in section 376.1350 for temporary or intermittent placement in health care facilities;

(4) Is an entity licensed pursuant to chapter 197;

(5) Is a public or private facility, day program, residential facility or specialized service operated, funded or licensed by the department of mental health; or

(6) Is a licensed adult day care provider.

2. For the purpose of this section "patient or resident" has the same meaning as such term is defined in section 43.540.

3. Prior to allowing any person who has been hired as a full-time, part-time or temporary position to have contact with any patient or resident the provider shall, or in the case of temporary employees hired through or contracted for an employment agency, the employment agency shall prior to sending a temporary employee to a provider:

(1) Request a criminal background check as provided in section 43.540. Completion of an inquiry to the highway patrol for criminal records that are available for disclosure to a provider for the purpose of conducting an employee criminal records background check shall be deemed to fulfill the provider’s duty to conduct employee criminal background checks pursuant to this section; except that, completing the inquiries pursuant to this subsection shall not be construed to exempt a provider from further inquiry pursuant to common law requirements governing due diligence. If an applicant has not resided in
this state for five consecutive years prior to the date of his or her application for employment, the provider shall request a nationwide check for the purpose of determining if the applicant has a prior criminal history in other states. The fingerprint cards and any required fees shall be sent to the highway patrol's central repository. The fingerprints shall be used for searching the state repository of criminal history information. If no identification is made, fingerprints shall be forwarded to the Federal Bureau of Investigation for the searching of the federal criminal history files. The patrol shall notify the submitting state agency of any criminal history information or lack of criminal history information discovered on the individual. The provisions relating to applicants for employment who have not resided in this state for five consecutive years shall apply only to persons who have no employment history with a licensed Missouri facility during that five-year period. Notwithstanding the provisions of section 610.120, all records related to any criminal history information discovered shall be accessible and available to the provider making the record request; and

(2) Make an inquiry to the department of health and senior services whether the person is listed on the employee disqualification list as provided in section 192.2490.

4. When the provider requests a criminal background check pursuant to section 43.540, the requesting entity may require that the applicant reimburse the provider for the cost of such record check. When a provider requests a nationwide criminal background check pursuant to subdivision (1) of subsection 3 of this section, the total cost to the provider of any background check required pursuant to this section shall not exceed five dollars which shall be paid to the state. State funding and the obligation of a provider to obtain a nationwide criminal background check shall be subject to the availability of appropriations.

5. An applicant for a position to have contact with patients or residents of a provider shall:

(1) Sign a consent form as required by section 43.540 so the provider may request a criminal records review;

(2) Disclose the applicant's criminal history. For the purposes of this subdivision "criminal history" includes any conviction or a plea of guilty to a misdemeanor or felony charge and shall include any suspended imposition of sentence, any suspended execution of sentence or any period of probation or parole;

(3) Disclose if the applicant is listed on the employee disqualification list as provided in section 192.2490; and

(4) Disclose if the applicant is listed on any of the background checks in the family care safety registry established under section 210.903. A provider not otherwise prohibited
from employing an individual listed on such background checks may deny employment to an individual listed on any of the background checks in such registry.

6. An applicant who knowingly fails to disclose his or her criminal history as required in subsection 5 of this section is guilty of a class A misdemeanor. A provider is guilty of a class A misdemeanor if the provider knowingly hires or retains a person to have contact with patients or residents and the person has been found guilty in this state or any other state or has been found guilty of a crime, which if committed in Missouri would be a class A or B felony violation of chapter 565, 566 or 569, or any violation of subsection 3 of section 198.070 or section 568.020.

7. Any in-home services provider agency or home health agency shall be guilty of a class A misdemeanor if such agency knowingly employs a person to provide in-home services or home health services to any in-home services client or home health patient and such person either refuses to register with the family care safety registry or if such person:

(1) Has any of the disqualifying factors listed in subsection 6 of this section;

(2) Has been found guilty of or pleaded guilty or nolo contendere to any felony offense under chapter* 195 or 579;

(3) Has been found guilty of or pleaded guilty or nolo contendere to any felony offense under section 568.045, 568.050, 568.060, 568.175, 570.023, 570.025, 570.030, 570.040 as it existed prior to January 1, 2017, 570.090, 570.145, 570.223, 575.230, or 576.080;

(4) Has been found guilty of or pleaded guilty or nolo contendere to a violation of section 577.010 or 577.012 and who is alleged and found by the court to be an aggravated or chronic offender under section 577.023;

(5) Has been found guilty of or pleaded guilty or nolo contendere to any offense requiring registration under section 589.400;

(6) Is listed on the department of health and senior services employee disqualification list under section 192.2490;

(7) Is listed on the department of mental health employee disqualification registry under section 630.170; or

(8) Has a finding on the child abuse and neglect registry under sections 210.109 to 210.183.

8. The highway patrol shall examine whether protocols can be developed to allow a provider to request a statewide fingerprint criminal records review check through local law enforcement agencies.

9. A provider may use a private investigatory agency rather than the highway patrol to do a criminal history records review check, and alternatively, the applicant pays the private investigatory agency such fees as the provider and such agency shall agree.
10. Except for the hiring restriction based on the department of health and senior services employee disqualification list established pursuant to section 192.2490, the department of health and senior services shall promulgate rules and regulations to waive the hiring restrictions pursuant to this section for good cause. For purposes of this section, "good cause" means the department has made a determination by examining the employee’s prior work history and other relevant factors that such employee does not present a risk to the health or safety of residents.


*Word "chapters" appears in original rolls.

Transferred 2014; formerly 660.317

<table>
<thead>
<tr>
<th>- All entries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective</td>
</tr>
<tr>
<td>192.2495</td>
</tr>
<tr>
<td>192.2495</td>
</tr>
<tr>
<td>192.2495</td>
</tr>
<tr>
<td>192.2495</td>
</tr>
</tbody>
</table>

In accordance with Section 3.090, the language of statutory sections enacted during a legislative session are updated and available on this website on the effective date of such enacted statutory section.

**Other Information**

<table>
<thead>
<tr>
<th>Tables and Forms</th>
<th>Sections with Definitions</th>
<th>Repealers / Transfers</th>
<th>MOGA</th>
</tr>
</thead>
</table>

[Seal of the State of Missouri] [Seal of House of Representatives]
Rules of
Department of Social Services
Division 70—MO HealthNet Division
Chapter 91—Personal Care Program

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 CSR 70-91.010 Personal Care Program</td>
<td>3</td>
</tr>
<tr>
<td>13 CSR 70-91.020 Mental Health Residential Personal Care Program</td>
<td>8</td>
</tr>
<tr>
<td>(Rescinded June 30, 2018)</td>
<td></td>
</tr>
<tr>
<td>13 CSR 70-91.030 Personal Care Assistance (Rescinded December 30, 2010)</td>
<td>8</td>
</tr>
</tbody>
</table>
Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 91—Personal Care Program

13 CSR 70-91.010 Personal Care Program

PURPOSE: Personal care services are medically-oriented services provided in the individual’s home, or in a licensed Residential Care Facility I or II to assist with activities of daily living to meet the physical needs of the individual. Personal care services are authorized by a physician in accordance with a plan of care or otherwise authorized in accordance with a service plan approved by the state. This rule establishes the basis for administering the personal care program, including the criteria providers of the service must meet, criteria a recipient of the service must meet, and criteria and method of reimbursement for the services. Specific details of the amount, duration, scope and limitations of services covered are included in the provider program manuals.

1) Persons Eligible for Personal Care Services. Any person who is determined eligible by the Family Support Division for Title XIX benefits and is found to be in medical need of personal care services as an alternative to institutional care. Persons must be assessed, approved and case managed by the Department of Health and Senior Services or its designee as described in this rule, to be eligible for personal care services. Eligibility procedures for personal care services are as follows:

(A) Requirements for Personal Care Services:

1. The recipient must need an institutional level of care which is defined as twenty-four (24)-hour institutional care on an inpatient or residential basis in a hospital or nursing facility (NF) and approved by the Department of Health and Senior Services or its designee.

2. Level of care will be determined by the Department of Health and Senior Services or its designee.

3. The recipient must agree to an in-home assessment performed by the Department of Health and Senior Services or its designee of his/her physical, social and functional ability to benefit from personal care services.

(B) Obtaining Personal Care Services.

1. If the recipient meets all of the eligibility and assessment criteria, the Department of Health and Senior Services or its designee will develop an initial personal care plan to authorize personal care services on a scheduled basis to eligible recipients in their own homes or licensed Residential Care Facility I or II as an alternative to twenty-four (24)-hour institutional care on an inpatient or residential basis in a hospital or NF. The Department of Health and Senior Services or its designee will forward a copy of the personal care plan to the client’s attending physician and to the personal care provider who will be delivering care. Upon the receipt of the personal care plan, the provider of care must initiate care within seven (7) days of receipt and the physician must register any comments or requests for changes, within thirty (30) days of receipt or the personal care plan will stand as written by the Department of Health and Senior Services or its designee.

2. The personal care plan will be developed in collaboration with and signed by the recipient. The plan will include a list of tasks to be performed, weekly schedule of service delivery, and the maximum number of units of service for which the recipient is eligible per month.

3. A new in-home assessment and personal care plan may be completed by the Department of Health and Senior Services or its designee as needed to re-determine need for personal care services or to adjust the monthly amount of authorized units. In collaboration with the service recipient, the service agency may develop a new or revised set of personal care tasks, and weekly schedule of service delivery which shall be forwarded to the Department of Health and Senior Services or its designee. The service provider must always have, and provide services in accordance with, a current service plan. Only the Department of Health and Senior Services or its designee, not the service provider, may increase the maximum number of units for which the individual is eligible per month. Any service plan developed in accordance with paragraphs (1)(B)(2) and 3. is a state approved service plan.

4. The recipient will be informed of the option of services available to him/her in accordance with the level-of-care determination and assessment findings; and

(C) Discontinuing Personal Care Services. The following policies and procedures for discontinuing personal care services shall be followed:

1. Services for a client shall be discontinued by a provider agency under the following circumstances:

A. When the client’s case is closed by the Department of Health and Senior Services or its designee;

B. When the provider learns of circumstances that require the closure of a case for reasons including, but not limited to:

   (2) Basic personal care services are medically-oriented, maintenance services to assist
with the activities of daily living when this assistance does not require devices and procedures related to altered body functions.

(A) To be eligible for basic personal care, an individual must be in need of personal care services as an alternative to institutional care as specified in section (1) of this rule.

(B) The following activities constitute basic personal care services and shall be provided according to the plan of care:

1. Assistance with dietary needs, including meal preparation and cleanup, and assistance with eating/feeding;
2. Assisting with dressing and grooming, including helping with dressing and undressing, combing hair, and nail care;
3. Assisting with bathing and personal hygiene, including assisting with bathing, shampooing hair, oral hygiene and denture care, and shaving;
4. Assisting with toileting and continence, including assisting in going to the bathroom, and changing bed linen. This category may also include the changing of beds for persons with medically related limitations that prohibit the completion of this task;
5. Assisting with mobility and transfer, including assisting with transfer and ambulation when recipient can at least partially bear own weight;
6. Assisting with medication, including assisting with the self-administration of medicine, applying nonprescription topical ointments or lotions; and
7. Medically related household tasks, including approved homemaker and chore tasks.

(C) The encouragement and instruction of recipients in self-care may be a component of any other task as described above; however, encouragement and instruction do not constitute a task in and of themselves.

(3) Criteria for Providers of Personal Care Services.

(A) The provider of personal care services must have a valid participation agreement with the state Medicaid agency. The issuance of the participation agreement is dependent upon the Department of Social Services’ acceptance of an application for enrollment. The provider must submit to the Department of Health and Senior Services, Division of Senior Services and Regulation, the written proposal required to become a Title XX in-home services provider and be approved to provide Title XX in-home services. Once approved to provide Title XX in-home services by the Division of Senior Services and Regulation, the provider will be allowed to execute a Title XIX participation agreement with the Division of Medical Services. Thereafter, a provider is not required to actually accept or deliver services to clients who are authorized for both programs or to clients who are authorized for Title XX services only. For residential care facilities that wish to provide services only to the eligible residents of their own facility, only the verification of a state residential care facility license will be required for the Medicaid enrollment application. Providers must maintain their approval to participate as a Title XX provider, whether or not they actually serve Title XX eligible clients, in order to remain qualified to participate in the Title XIX (Medicaid) Personal Care Program.

(B) The providers must agree to comply with any evaluation conducted by the Department of Social Services and Health and Senior Services. The Division of Senior Services and Regulation may, in accordance with the protective service mandate (Chapter 660, RSMo), take action to protect clients from providers who are found to be out of compliance with the requirements of its regulations and of any other regulations applicable to the Personal Care Program, when such noncompliance is determined by the Division of Senior Services and Regulation to create a risk of injury or harm to clients. Evidence of such risk may include: unreliable or inadequate provider documentation of services or training due to falsification or fraud; the provider's failure to deliver services in a reliable and dependable manner; or use of personal care aides who do not meet the minimum training standards of this regulation. Immediate action by the Division of Senior Services and Regulation may include, but is not limited to:

1. Removing the provider from any list of providers, and for clients who request the unsafe and noncompliant provider, informing the clients of the determination of noncompliance after which any informed choice will be honored by the Department of Health and Senior Services or its designee; or
2. Informing current clients served by the provider of the provider’s noncompliance and that the Division of Senior Services and Regulation has determined the provider unable to deliver safe care. Such clients will be allowed to choose a different provider from the list maintained by the Department of Health and Senior Services or its designee which will then be immediately authorized to provide service to them.

(C) The provider agency must be available to provide care in accordance with the personal care plan, utilizing universal precaution procedures as defined by the Center for Disease Control.

(D) The provider agency must monitor the overall physical care needs of the service recipient. If the client's condition warrants, contact the client's physician and inform the Department of Health and Senior Services or its designee when additional case management activities by the Department of Health and Senior Services or its designee are required.

(E) For newly employed aides, the provider agency must, at a minimum, provide twenty (20) hours of orientation training.

1. In calculating these hours, the following requirements shall apply:
   A. At least two (2) hours orientation to the provider agency and the agency's protocols for handling emergencies, within thirty (30) days of employment;
   B. With eight (8) hours of classroom training being completed prior to client contact;
   C. Twelve (12) hours of orientation may be waived with adequate documentation in the employee’s records that the aide received similar training during the current or preceding state fiscal year or has been employed as an aide at an in-home or home health agency at least half-time for six (6) months or more within the current or preceding state fiscal year.
   D. If an aide is a certified nurse assistant, licensed practical nurse, or registered nurse, the provider agency may waive all orientation training, except the two (2) hours' provider agency orientation, with documentation placed in the aide's personnel record. The documentation shall include the employee’s license or certification number current at the time the training was waived.
   2. An additional ten (10) hours of in-service training annually are required after the first twelve (12) months of employment. At least six (6) of the required ten (10) hours shall be classroom instruction. The additional four (4) hours may be via any appropriate training method. The provider may waive the required annual ten (10) hours of in-service training and require only two (2) hours of refresher training annually, when the aide has been employed for three (3) years and has completed thirty (30) hours of in-service training.
   3. Personal care aides employed by an RCF II are exempt from the training requirements defined in paragraphs (3)(E)(1) and 2. of this rule if they have completed the training requirements described in subdivisions (9) and (10) of subsection 3 of section 198.073, RSMo 2000.
   4. The provider agency shall have written documentation of all basic and in-service
training provided which includes, at a minimum, a report of each employee's training in that employee's personnel record. The record shall document the dates of all classroom or on-the-job training, trainer's name, topics, number of hours and location, the date of the first client contact and shall include the aide's signature. If a provider waives any in-service training, the employee's training record shall contain supportive data for the waiver.

(F) The requirements that have been adopted by the Division of Senior Services and Regulation at 19 CSR 15-7.021(18)(A) through (R) and (18)(U) through (W) shall apply to all providers of personal care services and advanced personal care services.

(G) The provider agency must employ an administrative supervisor of the day-to-day delivery of direct personal care services possessing at least the following qualifications:

1. Be at least twenty-one (21) years of age;
2. Shall be a registered nurse (RN) who is currently licensed in Missouri; or have at least a baccalaureate degree; or be a licensed practical nurse (LPN) who is currently licensed in Missouri with at least one (1) year of experience with the direct care of the elderly, disabled or infirm; or have at least three (3) years' experience with the care of the elderly, disabled or infirm.

(H) The supervisor's responsibilities shall include, at a minimum, the following:

1. Establish, implement, and enforce a policy governing communicable diseases that prohibits provider staff contact with clients when the employee has a communicable condition, including colds or flu. Assure that reporting requirements governing communicable diseases, including hepatitis and tuberculosis, are met by the Missouri Department of Health and Senior Services (19 CSR 20-20.020), are carried out;
2. Monitor the provision of services by the personal care worker to assure that services are being delivered in accordance with the personal care plan. This shall be primarily in the form of an at least monthly review and comparison of the worker's records of provided services with the personal care plan. The monitoring reports shall be available for review by the Departments of Social Services and Health and Senior Services upon request. Documentation must be kept on clients with a delivery rate of less than eighty percent (80%) of the authorized units of in-home service. For each client with a delivery rate less than eighty percent (80%) if the number of units of in-home services authorized for the time period being reviewed, the number of units of service delivered and the reason(s) for nondelivered services will be sent to the Department of Health and Senior Services monthly. Discrepancies for these clients concerning the frequency of delivered services and/or the in-home service tasks delivered, and the corrective action taken, will be signed and dated by the supervisor and be readily available for monitoring or inspection;
3. Make an on-site visit at least annually to evaluate each personal care worker's performance and the adequacy of the service plan, including review of the plan of care with the recipient. The personal care worker must be present for this evaluation. A written record of the evaluation shall be maintained in the personnel file of the personal care worker. This record must contain, at a minimum, the service recipient's name and address; the date and time of the visit, personal care worker's name and observations of both the personal care worker's performance and the adequacy of the service plan. In addition, the evaluation shall be signed and dated by the supervisor who prepared it and by the personal care worker. If the required evaluation is not performed or not documented, the personal care worker's qualifications to provide the services may be presumed inadequate and all payments made for services by that personal care worker may be recouped. Unless, medically, the recipient's condition supports a visit or all recipients have been visited, a service recipient shall not receive more than one (1) combined on-site supervisory visit and RN on-site visit as specified in paragraph (3)(O)(1) per state fiscal year;
4. Approve, in advance, all changes to the plan of care based on supervisory on-site visits, information from the personal care worker, or observation by the RN, or a combination of these. Approval of changes shall be noted and dated in the service recipient's file;
5. Make appropriate recommendations to the Department of Health and Senior Services or its designee including proposed increase, reduction or termination of services; or need for increased Department of Health and Senior Services case management involvement based on supervisory on-site visits, review of reports, information from the personal care worker, observation by the RN; or a combination of these;
6. Be available for regular case conferences with the Department of Health and Senior Services or its designee; and
7. Assist in orientation and personal care training for personal care workers.

(I) If the supervisor is not an RN, the provider agency must have a designated RN currently licensed in Missouri either on staff or employed as a consultant.

(J) The RN's responsibilities shall include, at a minimum, the following:

1. Monthly on-site visits of basic personal care recipients based on a ten percent (10%) sample of the provider agencies' combined Title XIX and Title XX caseload size as of the beginning of each month. This ten percent (10%) sample is to exclude personal care and advanced personal care recipients receiving authorized nurse visits and on-site supervisory visits, as specified in paragraph (3)(H)(3), unless all clients have already been seen or the recipient condition supports a visit. A maximum of thirty (30) visits will be required for those agencies that service over three hundred (300) recipients on a monthly basis with a minimum of two (2) visits monthly for agencies servicing fewer than twenty (20) clients monthly. The home visit shall consist of an evaluation of the adequacy of the plan of care in meeting the needs and condition of the recipient, and shall include a review of the plan of care with the recipient, and assessment of the personal care worker relative to his/her ability to carry out the plan of care. The RN must maintain an on-site visiting log. The log must contain, at a minimum, the service recipient's name, address, the date of the visit, the personal care worker's name and observations of both the personal care worker's performance and the adequacy of the service plan. Unless supported by the recipient's medical condition or all recipients have been visited, a service recipient shall not receive more than one (1) combined RN on-site visit and supervisory on-site visit as specified in paragraph (3)(H)(3) per state fiscal year;
2. Initial and review all on-site visit reports made by the personal care supervisor; and
3. If supervised by an RN, an LPN may perform the RN supervisory activities described in this section.

(K) An in-home personal care worker(s) shall meet the following requirements:

1. Be at least eighteen (18) years of age;
2. Be able to read, write and follow directions;
3. Have at least six (6) months' paid work experience as an agency homemaker, nurse aide or household worker, or at least one (1) year of experience, paid or unpaid, in caring for children, sick or aged individuals, or have successfully completed formal training, such as the basic nursing arts course of nurse's training, nursing assistant training or home health-aid training; and...
4. May not be a family member of the recipient for whom personal care is to be provided. A family member is defined as a parent; sibling; child by blood, adoption or marriage; spouse; grandparent or grandchild.

(4) Reimbursement.

(A) Payment will be made in accordance with the fee per unit of service as defined and determined by the Division of Medical Services.

1. A unit of service is fifteen (15) minutes.

2. Documentation for services delivered by the provider must include the following:

A. The recipient’s name and Medicaid number;

B. The date of service;

C. The time spent providing the service which must be documented in one of the following manners:

(I) When a personal care aide is providing services to one (1) individual in a private home setting and devotes undivided attention to the care required by that individual, the actual clock time the aide began the services for that visit shall be documented as the start time, and the actual clock time the aide finished the care for the visit shall be documented as the stop time; and

(II) When the personal care services are provided in a congregate living setting, such as a Residential Care Facility I and II, when on-site supervision is available and personal care aide staff will divide their time among a number of individuals, the following must be documented: all tasks performed for each recipient by date of services and by staff shifts during each twenty-four (24)-hour period;

D. A description of the service;

E. The name of the personal care aide who provided the service; and

F. For each date of service: the signature of the recipient, or the mark of the recipient witnessed by at least one (1) person, or the signature of another responsible person present in the recipient’s home or licensed Residential Care Facility I or II at the time of service. “Responsible person” may include the personal care aide’s supervisor, if the supervisor is present in the home at the time of service delivery. The personal care aide may only sign on behalf of the recipient when the recipient is unable to sign and there is no other responsible person present.

3. A provider may not bill time spent in the delivery of service of less than one (1) unit of service for any recipient. However, time spent in the delivery of service of less than one (1) full unit for any recipient may be accrued by the provider to establish a unit of service. In no event may time spent in the delivery of service be accrued beyond the last day of the calendar month in which such services were rendered.

4. The fee per unit of service will be based on the determination by the state agency of the reasonable cost of providing the covered services on a statewide basis and within the mandatory maximum payment limitations.

(B) Conditions for Reimbursement.

1. The personal care plan will be the authorization for payment of service.

2. The total monthly payment for basic personal care services made in behalf of an individual who requires basic personal care only cannot exceed sixty percent (60%) of the average statewide monthly cost for care in a nursing facility as defined in 13 CSR 70-10.010(4)(Q) (excluding intermediate care facilities for the mentally retarded (ICFs/MR)).

3. The average monthly cost to the state for care in NF as defined in 13 CSR 70-10.010(4)(Q) (excluding ICFs/MR) will be established in the month of May of each state fiscal year which will become effective on July 1 of the following state fiscal year.

4. Payment will be made on the lower of the established rate per service unit or the provider’s billed charges.

5. Rates will be established for personal care services in private homes and in licensed Residential Care Facilities I and II.

5. Advanced personal care services are maintenance services provided to a recipient in the individual’s home to assist with activities of daily living when this assistance requires devices and procedures related to altered body functions.

(A) Persons Eligible for Advanced Personal Care Services. Any person who is determined eligible for Title XIX benefits from the Family Support Division, found to be in need of personal care services as an alternative to institutional care as specified in section (1) of this rule, and who requires devices and procedures related to altered body functions is eligible for advanced personal care services.

(B) The following activities constitute advanced personal care services and shall be provided according to the plan of care:

1. Routine personal care of persons with ostomies (including tracheostomies, gastrostomies, colostomies all with well-healed stoma) which includes changing bags, and soap and water hygiene around ostomy site;

2. Personal care of persons with external, indwelling and suprapubic catheters which include changing bags, and soap and water hygiene around site;

3. Removal of external catheters, inspect skin and reapply catheter;

4. Administration of prescribed bowel programs, including use of suppositories and sphincter stimulation per protocol and enemas (prepacked only) with clients without contraindicating rectal or intestinal conditions;

5. Application of medicated (prescription) lotions, ointments or dry, aseptic dressings to unbroken skin including stage I decubitus;

6. Application of aseptic dressings to superficial skin breaks or abrasions as directed by a licensed nurse;

7. Manual assistance with noninjectable medications as set up by a licensed nurse;

8. Passive range of motion (nonresistive flexion of joint within normal range) delivered in accordance with the care plan; and

9. Use of assistive device for transfers.

(C) Instruction and encouragement to the client in ways to become more self-sufficient in advanced personal care may be a component of all tasks as described above; however, instruction and encouragement in and of themselves do not constitute a task.

(D) Advanced Personal Care Plans. Plans of care which include advanced personal care services must be developed by the provider agency RN in collaboration with state agency staff or its designee.

(E) Criteria for Providers of Advanced Personal Care Services. Providers of advanced personal care must meet all criteria for providers of personal care services described in section (3) of this rule. Providers must sign an addendum to their Title XIX Personal Care Provider Agreement, and must possess a valid contract with the Department of Health and Senior Services, Division of Senior Services and Regulation to provide Title XX services including advanced personal care services.

Residential care facilities wishing to provide advanced personal care services to the eligible residents of their own facility only may do so with only a signed addendum to their Title XIX Personal Care Provider Agreement.

1. All advanced personal care aids employed by the provider must be an LPN, or a certified nurse assistant; or an competency evaluated home health aide having completed both written and demonstration portions of the test required by the Missouri Department of Health and Senior Services and 42 CFR 484.36; or have successfully worked for the provider for a minimum of three (3) consecutive months while working at least fifteen (15) hours per week as an in-home aide that
has received personal care training. In addition, advanced personal care aides may not be
related to the recipient to whom they provide personal care, as defined in paragraph
(3)(K)(4) of this rule.

2. Personal care providers are required to provide training to advanced personal care
aides, in addition to the preservice training requirements described in section (3) of
this rule. The additional training shall consist of eight (8) classroom hours and must be
completed prior to the provision of any advanced personal care tasks. Providers may waive
this eight (8) hours of training if one of the following are met:

A. The proposed advanced personal care (APC) aide is an LPN or certified nurse
assistant (CNA) currently licensed or registered in the state of Missouri; or

B. The proposed advanced personal care aide has previously completed advanced personal
care training from a Medicaid or Social Services Block Grant (SSBG) in-home
provider agency, and that same personal care aide has been employed at least half-time by
a Medicaid or SSBG in-home provider agency as an advanced personal care aide within
the prior six (6) months.

3. Advanced personal care aides employed by an RCF II are exempt from the
training requirements defined in paragraphs (5)(E)(1) and (2) of this rule if they have
completed the training requirements described in subdivisions (9) and (10) of subsection 3
of section 198.073, RSMo 2000, as amended.

4. The additional advanced personal care training must include, at a minimum, the
following topics:

A. Observation of the client and reporting observation;
B. Application of ointments/lotions to unbroken skin;
C. Manual assistance with oral medications;
D. Prevention of decubitus;
E. Bowel routines (rectal supposito-
ries, sphincter stimulation);
F. Enemas;
G. Personal care for persons with ostomies and catheters;
H. Proper cleaning of catheter bags;
I. Positioning and support of the
client;
J. Range of motion exercises;
K. Application of nonslippage dressings
to superficial skin breaks; and
L. Universal precaution procedures as
defined by the Center for Disease Control.

5. Advanced personal care tasks as specified at (5)(B)(1) through (9) shall not be
assigned to or performed by any advanced personal care aide who is not a licensed nurse
until the aide has been fully trained to per-
form the task, the RN supervisor has personally observed successful execution of the task
and the RN supervisor has personally certi-
fied this in the aide’s personnel record. Only RN visits necessary for task observation and
certification in the home may be prior au-
thorized and billed to Medicaid as an authorized
nurse visit, as described in section (6) of
this rule. RN task observation and certification in a laboratory, or other non-home setting, may
not be billed.

6. The RN supervisor may observe the
execution of any of the tasks in a recipient’s
home. However, tasks specified in paragraphs
(5)(B)(1). . .(9) must be observed in the home, while those specified in para-
graphs (5)(B)(5). . .(8) may be observed in either a home or lab setting.

7. For clients receiving advanced personal
care services, it is required that on-site
RN visits be conducted at intervals of no
greater than six (6) months. During these vis-
its, the RN must conduct and contemporane-
ously record and certify by his/her signature
an individualized valuation of the client’s
condition and the adequacy of the service
plan.

(F) Reimbursement.
1. Payment for advanced personal care
services will be made in accordance with the
fee per unit of service as defined and deter-
mimed by the Division of Medical Services.
The fee per unit (fifteen (15) minutes) of ser-
vice will be based on the determination of
the state agency of the reasonable cost of provid-
ing the covered services on a statewide basis
and within the mandatory maximum payment
limitations.

2. Conditions for reimbursement.
A. An advanced personal care plan is
required. It is to be developed by the
Department of Health and Senior Services
or its designee in cooperation with the provider
agency’s RN. The provider agency is respon-
sible for obtaining the recipient’s physician’s
approval for the plan.

B. The total monthly payment for advanced personal care services as described
in this section and for personal care services as described in sections (1)–(7)
of this rule made in behalf of an individual cannot exceed
one hundred percent (100%) of the average
statewide monthly cost for care in an NF as
defined in 13 CSR 70-10.010(4)(Q), (excluding
ICFs/RR).

C. The average monthly cost to the
state for care in an NF, as defined in 13 CSR
70-10.010(4)(Q), excluding ICF/MR, will
be established in the month of May of each
state fiscal year which will become effective
on July 1 of the following state fiscal year.

D. Payment will be made on the lower
of the established rate per service unit or the
provider’s billed charges.

3. Rates will be established for personal
care services in private homes and in licensed
Residential Care Facilities I and II.

(6) Separately Authorized Nurses Visits.
A. The provisions of paragraphs (3)(J) and (3)(H)3. notwithstanding, reim-
bursement will be made for visits by a nurse to
particular clients with special needs, when
the visits are prior authorized by the
Department of Health and Senior Services
or its designee. Providers of personal care
services must have the capacity to provide these
authorized nurse visits in addition to the
nonauthorized nurse visits required by sub-
section (3)(J); however, any client who
receives an authorized nurse visit in one (1)
month shall not be included in the population
from which the ten percent (10%) sample for
that month’s supervisory visits is drawn in
accordance with paragraph (3)(J). Anytime an
authorized nurse visit is made, the nurse shall
also, in addition to other duties, evalu-
ate the adequacy of the plan of care, includ-
ing a review of the plan of care with the
recipient.

B. To be eligible to receive the authorized
nurse visit, the recipient must—

1. Be determined eligible for Title XIX
benefits from the Family Support Division
and found to be in need of personal care
services as an alternative to institutional care as
specified in section (1) of this rule;

2. Have no other person available who
could and would provide the services;

3. Require one (1) or more of the
services described in subsection (6)(D) as
an alternative to institutional care;

4. Meet any additional criteria of need
set forth in subsection (6)(D).

C. The services provided during the
authorized nurse visit shall not include any
service which the client would be eligible
to receive under either the Medicare
(Title XVIII) or Medicaid (Title XIX) Home Health
programs. The services listed in subsection
(6)(D) do not qualify, by themselves, for
reimbursement under either program.

However, should a client otherwise be eligi-
ble for home health services, then those
services listed in paragraphs (6)(D) will be
provided by the home health agency and not
under the Personal Care Program.

D. The services of the nurse shall provide
increased supervision of the aide, assessment
of the client’s health and the suitability of the
care plan to meet the client’s needs. These

JOHN R. ASHCRAFT
Secretary of State
(5/31/18)

CODE OF STATE REGULATIONS
services also shall include any referral or follow-up action indicated by the nurse’s assessment. These services, in addition, must include one (1) or more of the following where appropriate to the needs of the client and authorized by the Department of Health and Senior Services or its designees:

1. The RN may fill a one (1)-week supply of insulin syringes for diabetics who can self-inject the medication but cannot fill their own syringes. This service would include monitoring the patient’s continued ability to self-administer the insulin;

2. The RN may set up oral medications in divided daily compartments for a client who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

3. The RN may monitor a recipient’s skin condition when a client is at risk of skin breakdown due to immobility, incontinence, or both;

4. The RN may provide nail care for a diabetic or client with other medically contraindicating conditions, if the recipient is unable to perform this task;

5. The RN will be authorized to visit all personal care recipients who also receive advanced personal care as described in section (4) of this rule, on a monthly basis, to evaluate the adequacy of the authorized services to meet the needs and conditions of the client, and to assess the advanced personal care aide’s ability to carry out the authorized services;

6. The RN may provide on-the-job training to advanced personal care aides as described in paragraph (3)(E)(6) of this rule;

7. The visits authorized under section (6) except (6)(D)(6) may be carried out by an LPN, if under the direction of an RN; or

8. The RN may be authorized to provide other services in other situations, subject to the conditions set forth in subsection (6)(C).

(E) Payment for the authorized nurse visit will be made in accordance with the fee per unit of service as defined and determined by the Division of Medical Services.

1. A unit of service is the visit. No minimum or maximum time is required to constitute a visit.

2. The maximum number of units which a client can receive is twenty-six (26) within a six (6)-month period of time. The cost of the nurse visits are not included in the spending cap set forth in paragraph (4)(B)(2), but must be included in the spending cap specified at subparagraph (5)(F)(2).B.

(F) Documentation of the authorized nurse visit shall include written notes and observations. These will be maintained in the recipient’s file. In addition, notes of any verbal communication and copies of any written communications with the recipient’s physician or other health care professional concerning the care of that recipient also will be maintained in the recipient’s file.


13 CSR 70-91.030 Personal Care Assistance

(Rescinded December 30, 2010)


13 CSR 70-91.020 Mental Health Residential Personal Care Program

(Rescinded June 30, 2018)

AUTHORITY: sections 208.152, RSMo Supp.
# Rules of Department of Social Services
## Division 70—MO HealthNet Division
### Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 CSR 70-3.020 Title XIX Provider Enrollment</td>
<td>3</td>
</tr>
<tr>
<td>13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for MO HealthNet Services</td>
<td>5</td>
</tr>
<tr>
<td>13 CSR 70-3.040 Duty of Medicaid Participating Hospitals and Other Vendors to Assist in Recovering Third-Party Payments (Rescinded November 30, 2018)</td>
<td>11</td>
</tr>
<tr>
<td>13 CSR 70-3.050 Obtaining Information From Providers of Medical Services</td>
<td>11</td>
</tr>
<tr>
<td>13 CSR 70-3.060 Medicaid Program Payment of Claims for Medicare Part B Services (Rescinded August 11, 1988)</td>
<td>11</td>
</tr>
<tr>
<td>13 CSR 70-3.100 Filing of Claims, MO HealthNet Program</td>
<td>11</td>
</tr>
<tr>
<td>13 CSR 70-3.105 Timely Payment of MO HealthNet Claims</td>
<td>13</td>
</tr>
<tr>
<td>13 CSR 70-3.120 Limitations on Payment of Out-of-State Nonemergency Medical Services</td>
<td>14</td>
</tr>
<tr>
<td>13 CSR 70-3.130 Computation of Provider Overpayment by Statistical Sampling</td>
<td>14</td>
</tr>
<tr>
<td>13 CSR 70-3.140 Direct Deposit of Provider Reimbursement</td>
<td>16</td>
</tr>
<tr>
<td>13 CSR 70-3.150 Authorization To Receive Payment for Medicaid Services</td>
<td>16</td>
</tr>
<tr>
<td>13 CSR 70-3.160 Electronic Submission of MO HealthNet Claims and Electronic Remittance Advices</td>
<td>17</td>
</tr>
<tr>
<td>13 CSR 70-3.170 Medicaid Managed Care Organization Reimbursement Allowance</td>
<td>18</td>
</tr>
<tr>
<td>13 CSR 70-3.180 Medical Pre-Certification Process</td>
<td>20</td>
</tr>
<tr>
<td>13 CSR 70-3.190 Telehealth Services (Rescinded January 30, 2019)</td>
<td>20</td>
</tr>
<tr>
<td>13 CSR 70-3.200 Ambulance Service Reimbursement Allowance</td>
<td>20</td>
</tr>
</tbody>
</table>
Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

13 CSR 70-3

regardless of when the services were rendered.

(8) MO HealthNet provider identifiers are contingent upon the applying provider receiving a favorable determination of compliance with Civil Rights requirements from the Office of Civil Rights (OCR). If OCR approval is not obtained and maintained, any reimbursement received shall be recouped.

(9) The provider is responsible for all services provided and all claims filed using her/his MO HealthNet provider identifier regardless of whom the reimbursement is paid and regardless of whom in her/his employ or services produced or submitted the MO HealthNet claim, or both. The provider is responsible for submitting proper diagnosis codes, procedure codes, and billing codes. When the length of time actually spent providing a service (begin and end time) is required to be documented, the provider is responsible for documenting such length of time by documenting the starting clock time and the end clock time, except for services as specified pursuant to 13 CSR 70-91.010(4)(A), Personal Care Program, regardless to whom the reimbursement is paid and regardless of whom in the provider’s employ or services produced or submitted the MO HealthNet claim.

(10) MO HealthNet provider identifiers shall not be released to any non-governmental entity, except the enrolled provider, by the MO HealthNet Division or its agents.

(11) MO HealthNet reimbursement shall not be made for any services performed by an individual not enrolled as a MO HealthNet provider, except for those services performed by the employee of the enrolled provider who is acting within their scope of practice and under the direct supervision of the enrolled provider. For example, an enrolled psychology or therapy provider may only bill for services that they actually perform. Psychology, therapy, and psychiatric services reimbursed through the physician program do not allow billing for supervised services.

(12) A provider that receives payment or makes payment of five (5) million dollars or more in a federal fiscal year under the MO HealthNet program must annually attest that the provider complies with the provisions of section 6032 of the federal Deficit Reduction Act of 2005. If a provider furnishes items or services at more than a single location or under more than one (1) contractual or other payment arrangement, the provisions apply to that provider if the aggregate payments total five (5) million dollars or more. A provider meeting this dollar threshold and having more than one (1) federal tax identification number shall provide the single state agency written notification of each associated federal tax identification number, each associated provider name, and each associated MO HealthNet provider identifier by September 30 of each year. The provider’s annual attestation must be made by March 1 of each year. The provider must provide a copy of the attestation within thirty (30) days upon the request of the single state agency. Any provider that claims an exemption from the provisions of section 6032 of the federal Deficit Reduction Act of 2005 must prove proof of such exemption within thirty (30) days upon the request of the single state agency.


13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for MO HealthNet Services

PURPOSE: This rule establishes the basis on which certain claims for MO HealthNet services or merchandise will be determined to be false or fraudulent and lists the sanctions which may be imposed and the method of imposing those sanctions.

PUBLISHER’S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration.

(A) The MO HealthNet program shall be administered by the Department of Social Services, MO HealthNet Division. The services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the division and shall be included in the MO HealthNet provider manuals, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website dis.mo.gov/mhd. October 1, 2017. This rule does not incorporate any subsequent amendments or additions.

(B) When a rule published in the Missouri Code of State Regulations relating to a specific provider type or service incorporates by reference a MO HealthNet provider manual which contains a later date of incorporation than 13 CSR 70-3.030, the manual incorporated into the more specific rule shall be applied in place of the manual incorporated into 13 CSR 70-3.030.

(2) The following definitions will be used in administering this rule:

(A) Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. "Adequate medical records" are records which are of the type and in a form from which symptoms, conditions, diagnosis, treatments, prognosis, and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered. An adequate and complete patient record is a record which is legible, which is made contemporaneously with the delivery of the service, which addresses the patient/client specifics, which include, at a minimum, individualized statements that support the assessment or treatment encounter, and shall include documentation of the following information:

1. First name, last name, and either middle initial or date of birth of the MO HealthNet participant;
2. An accurate, complete, and legible description of each service(s) provided;
3. Name, title, and signature of the MO HealthNet enrolled provider delivering the service. Inpatient hospital services must have signed and dated physician or psychologist orders within the patient’s medical record for the admission and for services billed to MO HealthNet. For patients registered on hospital
records as outpatient, the patient's medical record must contain signed and dated physician orders for services billed to MO HealthNet. Services provided by an individual under the direction or supervision are not reimbursed by MO HealthNet. Services provided by a person not enrolled with MO HealthNet are not reimbursed by MO HealthNet;

4. The name of the referring entity, when applicable;

5. The date of service (month/day/year);

6. For those MO HealthNet programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) (except for services American Medical Association Current Procedural Terminology procedure codes 99291–99292 and targeted case management services administered through the Department of Mental Health and as specified under 13 CSR 70.9.010 Personal Care Program (4)(A) the actual begin and end time taken to deliver the service (for example, 4:00–4:30 p.m.) must be documented;

7. The setting in which the service was rendered;

8. The plan of treatment, evaluation(s), tests(s), findings, results, and prescription(s) as necessary. Where a hospital acts as an independent laboratory or independent radiology service for persons considered by the hospital as “nonhospital” patients, the hospital must have a written request or requisition slip ordering the tests or procedures;

9. The need for the service(s) in relationship to the MO HealthNet participant's treatment plan;

10. The MO HealthNet participant's progress toward the goals stated in the treatment plan (progress notes);

11. Long-term care facilities shall be exempt from the seventy-two- (72-) hour documentation requirements rules applying to paragraphs (2)(A)9. and (2)(A)10. However, applicable documentation should be contained and available in the entirety of the medical record;

12. For applicable programs, it is necessary to have adequate invoices, trip tickets/reports, activity log sheets, employee records (excluding health records), and training records of staff; and

13. For targeted case management services administered through the Department of Mental Health, documentation shall include:
   A. First name, last name, and either middle initial or date of birth of the MO HealthNet participant;
   B. An accurate, complete, and legible case note of each service provided;
   C. Name of the case manager providing the service;
   D. Date the service was provided (month/day/year);
   E. Amount of time in minutes/hour(s) spent completing the activity;
   F. Setting in which the service was rendered;
   G. Individual treatment plan or person centered plan with regular updates;
   H. Progress notes;
   I. Discharge summaries when applicable;
   J. Other relevant documents referenced in the case note such as letters, forms, quarterly reports, and plans of care;
   (B) Affiliates means persons having an overt, covert, or conspiratorial relationship so that any one (1) of them directly or indirectly controls or has the power to control another;
   (C) Closed-end provider agreement means an agreement that is for a specified period of time, not to exceed twelve (12) months, and that must be renewed in order for the provider to continue to participate in the MO HealthNet program;
   (D) Contemporaneous means at the time the service was performed or within five (5) business days, at the time the service was provided;
   (E) Federal health care program means a program as defined in section 1128B(f) of the Social Security Act;
   (F) Fiscal agent means an organization under contract to the state MO HealthNet agency for providing any services in the administration of the MO HealthNet program;
   (G) MO HealthNet agency or the agency means the single state agency administering or supervising the administration of a state Medicaid plan;
   (H) Open-end provider agreement means an agreement that has no specific termination date and continues in force as long as it is agreeable to both parties;
   (I) Participation means the ability and authority to provide services or merchandise to eligible MO HealthNet participants and to receive payment from the MO HealthNet program for those services or merchandise;
   (J) Person means any natural person, company, firm, partnership, unincorporated association, corporation, or other legal entity;
   (K) Provider means an individual, firm, corporation, pharmacy, hospital, long-term care facility, association, or institution which has a provider agreement to provide services to a participant pursuant to Chapter 208, RMS;
   (L) Record means any books, papers, journals, charts, treatment histories, medical histories, tests and laboratory results, photographs, X-rays, and any other recordings of data or information made by or caused to be made by a provider relating in any way to services provided to MO HealthNet participants and payments charged or received. MO HealthNet claim for payment information, appointment books, financial ledgers, financial journals, or any other kind of patient charge without corresponding adequate medical records do not constitute adequate documentation;
   (M) Supervision means to direct an employee of the provider in the performance of a covered and allowable service such as under the MO HealthNet dental and nurse midwife programs or a covered and allowable nonpsychiatric service under the MO HealthNet physician program. In order to direct the performance of such service, the provider must be in the office where the service is being provided and must be immediately available to give directions in person to the employee actually rendering the service and the adequately documented service must be signed by the enrolled billing provider;
   (N) Suspension from participation means an exclusion from participation for a specified period of time;
   (O) Suspension of payments means placement of payments due a provider in an escrow account;
   (P) Termination from participation means the ending of participation in the MO HealthNet program;
   (Q) Withholding of payments means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

(3) Program Violations.
   (A) Sanctions may be imposed by the MO HealthNet agency against a provider for any one (1) or more of the following reasons:
   1. Presenting, or causing to be presented, for payment any false or fraudulent claim for services or merchandise in the course of business related to MO HealthNet;
   2. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is entitled under applicable MO HealthNet program policies or rules, including, but not limited to, the billing or coding of services which results in payments in excess of the fee schedule for the service actually provided or billing or coding of services which results in payments in excess of the provider's charges to the general public for the same services or billing for higher level of service or increased number of units from those actually ordered or performed or both.
or altering or falsifying medical records to obtain or verify a greater payment than authorized by a fee schedule or reimbursement plan;
3. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements or for the purpose of obtaining payments in order to avoid the effect of those changes;
4. Failing to make available, and disclosing to the MO HealthNet agency or its authorized agents, all records relating to services provided to MO HealthNet participants or records relating to MO HealthNet payments, whether or not the records are commingled with non-Title XIX (Medicaid) records. All records must be kept a minimum of five (5) years from the date of service unless a more specific provider regulation applies. The minimum five- (5)-year retention of records requirement continues to apply in the event of a change of ownership or discontinuing enrollment in MO HealthNet. Services billed to the MO HealthNet agency that are not adequately documented in the patient’s medical records or for which there is no record that services were performed shall be considered a violation of this section. Copies of records must be provided upon request of the MO HealthNet agency or its authorized agents, regardless of the media in which they are kept. Failure to make these records available on a timely basis at the same site at which the services were rendered or at the provider’s address of record with the MO HealthNet agency, or failure to provide copies as requested, or failure to keep and make available adequate records which adequately document the services and payments shall constitute a violation of this section and shall be a reason for sanction. Failure to send records, which have been requested via mail, within the specified time frame shall constitute a violation of this section and shall be a reason for sanction;
5. Failing to provide and maintain quality, necessary, and appropriate services, including adequate staffing for long-term care facility MO HealthNet participants, within accepted medical community standards as adjudged by a body of peers, as set forth in both federal and state statutes or regulations. Failure shall be documented by repeat discrepancies. The discrepancies may be determined by a peer review committee, medical review teams, independent professional review teams, utilization review committees, or by Professional Standards Review Organizations (PSRO). The medical review may be conducted by qualified peers employed by the single state agency;
6. Engaging in conduct or performing an act deemed improper or abusive of the MO HealthNet program or continuing the conduct following notification that the conduct should cease. This will include inappropriate or improper actions relating to the management of participants’ personal funds or other funds;
7. Breaching of the terms of the MO HealthNet provider agreement of any current written and published policies and procedures of the MO HealthNet program (Such policies and procedures are contained in provider manuals or bulletins which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/mhd, October 1, 2017. This rule does not incorporate any subsequent amendments or additions or fail to comply with the terms of the provider certification on the MO HealthNet claim form;
8. Utilizing or abusing the MO HealthNet program as evidenced by a documented pattern of inducing, furnishing, or otherwise causing a participant to receive services or merchandise not otherwise required or requested by the participant, attending physician, or appropriate utilization review team; a documented pattern of performing and billing tests, examinations, patient visits, surgeries, drugs, or merchandise that exceed limits or frequencies determined by the department for like practitioners for which there is no demonstrable need, or for which the provider has created the need through ineffective services or merchandise previously rendered;
9. Refhitting or accepting a fee or portion of a fee or charge for a MO HealthNet patient referral; or collecting a portion of the service fee from the participant, except this shall not apply to MO HealthNet services for which participants are responsible for payment of a copayment or coinsurance in accordance with 13 CSR 70-4.050 and 13 CSR 70-4.051;
10. Violating any provision of the State Medical Assistance Act or any corresponding rule;
11. Submitting a false or fraudulent application for provider status which misrepresents material facts. This shall include concealment or misrepresentation of material facts required on any provider agreements or questionnaires submitted by affiliates when the provider knew, or should have known, the contents of the submitted documents;
12. Violating any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries. In addition to all other laws which would commonly be understood to govern or regulate the conduct of occupations, professions, or regulated industries, this provision shall include any violations of the civil or criminal laws of the United States, of Missouri, or any other state or territory, where the violation is reasonably related to the provider’s qualifications, functions, or duties in any licensed or regulated profession or where an element of the violation is fraud, dishonesty, moral turpitude, or an act of violence;
13. Failing to meet standards required by state or federal law for participation (for example, licensure);
14. Exclusion from the Medicare program or any other federal health care program;
15. Failing to accept MO HealthNet payment as payment in full for covered services or collecting additional payment from a participant or responsible person, except this shall not apply to MO HealthNet services for which participants are responsible for payment of a copayment or coinsurance in accordance with 13 CSR 70-4.050 and 13 CSR 70-4.051;
16. Refusing to execute a new provider agreement when requested to do so by the single state agency in order to preserve the single state agency’s compliance with federal and state requirements; or failure to execute an agreement within twenty (20) days for compliance purposes;
17. Failing to correct deficiencies in provider operations within ten (10) days or date specified after receiving written notice of these deficiencies from the single state agency or within the time frame provided from any other agency having licensing or certification authority;
18. Being formally reprimanded or censured by a board of licensure or an association of the provider’s peers for unethical, unlawful, or unprofessional conduct; any termination, removal, suspension, revocation, denial, probation, consented surrender, or other disqualification of all or part of any license, permit, certificate, or registration related to the provider’s business or profession in Missouri or any other state or territory of the United States;
19. Being suspended or terminated from participation in another governmental medical program such as Workers’ Compensation, Crippled Children’s Services, Rehabilitation Services, Title XX Social Service Block Grant, or Medicare;
20. Using fraudulent billing practices arising from billings to third parties for costs of services or merchandise or for negligent practice resulting in death or injury or substandard care to persons including, but not limited to, the provider’s patients;
21. Failing to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments...
prior to the allowed forty-five (45) days which the provider has to refund the requested amount;

22. Billing the MO HealthNet program more than once for the same service when the billings were not caused by the single state agency or its agents;

23. Billing the state MO HealthNet program for services not provided prior to the date of billing (prebilling), except in the case of prepaid health plans or pharmacy claims submitted by point-of-service technology; whether or not the prebilling causes loss or harm to the MO HealthNet program;

24. Failing to reverse or credit back to the medical assistance program (MO HealthNet) within thirty (30) days any pharmacy claims submitted to the agency that represent products or services not received by the participant; for example, prescriptions that were returned to stock because they were not picked up;

25. Conducting any action resulting in a reduction or depletion of a long-term care facility MO HealthNet participant’s personal fund or reserve account, unless specifically authorized in writing by the participant, relative, or responsible person;

26. Submitting claims for services not personally rendered by the individually enrolled provider, except for the provisions specified in the MO HealthNet dental, physicians, or nurse midwife programs where such claims may be submitted only if the individually enrolled provider directly supervised the person who actually performed the service and the person was employed by the enrolled provider at the time the service was rendered. All claims for psychiatric, psychological counseling, speech therapy, physical therapy, and occupational therapy services may only be billed by the individually enrolled provider who actually performs the service, as supervision is noncovered for these services. Services performed by a nonenrolled person due to MO HealthNet sanction, whether or not the person was under supervision of the enrolled provider, is a noncovered service;

27. Making any payment to any person in return for referring an individual to the provider for the delivery of any goods or services for which payment may be made in whole or in part under MO HealthNet. Soliciting or receiving any payment from any person in return for referring an individual to another supplier of goods or services regardless of whether the supplier is a MO HealthNet provider for the delivery of any goods or services for which payment may be made in whole or in part under MO HealthNet is also prohibited. Payment includes, without limitation, any kickback, bribe, or rebate made, either directly or indirectly, in cash or in kind;

28. Billing for services through an agent, which were upgraded from those actually ordered, performed; or billing or coding services, either directly or through an agent, in a manner that services are paid for as separate procedures when, in fact, the services were performed concurrently or sequentially and should have been billed or coded as integral components of a total service as prescribed in MO HealthNet policy for payment in a total payment less than the aggregate of the improperly separated services; or billing a higher level of service than is documented in the patient/client record; or unbundling procedure codes;

29. Conducting civil or criminal fraud against the MO HealthNet program or any other state Medicaid (medical assistance) program, or any criminal fraud related to the conduct of the provider’s profession or business;

30. Having sanctions or any other adverse action invoked by another state Medicaid program;

31. Failing to take reasonable measures to review claims for payment for accuracy, duplication, or other errors caused or committed by employees when the failure allows material errors in billing to occur. This includes failure to review remittance advice statements provided which results in payments which do not correspond with the actual services rendered;

32. Submitting improper or false claims to the state or its fiscal agent by an agent or employee of the provider;

33. Failing to maintain records for services other than long-term care facilities, to retain in legible form for at least five (5) years from the date of service, worksheets, financial records, appointment books, appointment calendars (for those providers who schedule patient/client appointments), adequate documentation of the service, and other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not. For long-term care providers, failure to retain in legible form, for at least seven (7) years from the date of service, worksheets, financial records, adequate documentation for the service(s), and other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not. The documentation must be maintained so as to protect it from damage or loss by fire, water, computer failure, theft, or any other cause;

34. Removing or coercing from the possession or control of a participant any item of durable medical equipment which has reached MO HealthNet-defined purchase price through MO HealthNet rental payments or otherwise become the property of the participant without paying fair market value to the participant;

35. Failing to timely submit civil rights compliance data or information or failure to timely take corrective action for civil rights compliance deficiencies within thirty (30) days after notification of these deficiencies or failure to cooperate or supply information required or requested by civil rights compliance officers of the single state agency;

36. Billing the MO HealthNet program for services rendered to a participant in a long-term care facility when the resident resided in a portion of the facility which was not MO HealthNet-certified or properly licensed or was placed in a nonlicensed or MO HealthNet-noncertified bed;

37. Failure to comply with the provisions of the Missouri Department of Social Services, MO HealthNet Division Title XIX Participation Agreement with the provider relating to health care services;

38. Failure to maintain documentation which is to be made contemporaneously to the date of service;

39. Failure to maintain records for services provided and all billing done under his/her provider number regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the MO HealthNet claim or both;

40. Failure to submit proper diagnosis codes, procedure codes, billing codes regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the MO HealthNet claim;

41. Failure to submit and document, as defined in subsection (2)(A) of the time of length (begin and end clock time) actually spent providing a service, except for services as specified under 13 CSR 70-9.010(41) Personal Care Program, regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the MO HealthNet claim or both;

42. Billing for the same service as another provider when the service is performed or attended by more than one (1) enrolled provider. MO HealthNet will reimburse only one (1) provider for the exact same service;

43. Failing to make an annual attestation of compliance with the provisions of Section 6032 of the federal Deficit Reduction Act of 2005 by March 1 of each year, or failing to provide a requested copy of an attestation, or failing to provide written notification of having more than one (1) federal tax identification number by September 30 of each year, or
Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

13 CSR 70-3

failing to provide requested proof of a claimed exemption from the provisions of section 4032 of the federal Deficit Reduction Act of 2005; and

44. Failing to advise the single state agency, in writing, on enrollment forms specified by the single state agency, of any changes affecting the provider’s enrollment records within ninety (90) days of the change, with the exception of change of ownership or control of any provider which must be reported within thirty (30) days.

4) Any one (1) or more of the following sanctions may be invoked against providers for any one (1) or more of the program violations specified in section (3) of this rule:

(A) Failure to respond to notice of overpayments or notice of deficiencies in provider operations within the specified forty-five (45)-day time limit shall be considered cause to withhold future provider payments until the situation in question is resolved;

(B) Termination from participation in the MO HealthNet program for a period of not less than sixty (60) days nor more than ten (10) years;

(C) Suspension of participation in the MO HealthNet program for a specified period of time;

(D) Suspension or withholding of payments to a provider;

(E) Referral to peer review committees including PSROs or utilization review committees;

(F) Recoupment from future provider payments;

(G) Transfer to a closed-end provider agreement not to exceed twelve (12) months or the shortening of an already existing closed-end provider agreement;

(H) Attendance at provider education sessions;

(I) Prior authorization of services;

(J) One hundred percent (100%) review of the provider’s claims prior to payment;

(K) Referral to the state licensing board for investigation;

(L) Referral to appropriate federal or state legal agency for investigation, prosecution, or both, under applicable federal and state laws;

(M) Retroactive denial of payments; and

(N) Denial of payment for any new admission to a skilled nursing facility (SNF), intermediate care facility (ICF), or ICF/individuals with intellectual disabilities (IID) that no longer meets the applicable conditions of participation (for SNFs) or standards (for ICFs and ICF/IIDs) if the facility’s deficiencies do not pose immediate jeopardy to patients’ health and safety. Imposition of this sanction must be in accordance with all applicable federal statutes and regulations.

(5) Imposition of a Sanction.

(A) The decision as to the sanction to be imposed shall be at the discretion of the MO HealthNet agency. The following factors shall be considered in determining the sanction(s) to be imposed:

1. Seriousness of the offense(s)—The state agency shall consider the seriousness of the offense(s) including, but not limited to, whether or not an overpayment (that is, financial harm) occurred to the program, whether substandard services were rendered to MO HealthNet participants, or circumstances were such that the provider’s behavior could have caused or contributed to inadequate or dangerous medical care for any patient(s), or a combination of these. Violation of pharmacy laws or rules, practices potentially dangerous to patients, and fraud are to be considered particularly serious;

2. Extent of violations—The state MO HealthNet agency shall consider the extent of the violations as measured by, but not limited to, the number of patients involved, the number of MO HealthNet claims involved, the number of dollars identified in any overpayment, and the length of time over which the violations occurred. The MO HealthNet agency may calculate an overpayment or impose sanctions under this rule by reviewing records pertaining to all or part of a provider’s MO HealthNet claims. When records are examined pertaining to part of a provider’s MO HealthNet claims, no random selection process in choosing the claims for review as set forth in 13 CSR 70-3.130 need be utilized by the MO HealthNet agency. But, if the random selection process is not used, the MO HealthNet agency may not construe violations found in the partial review to be an indication that the extent of the violations in any unreviewed claims would exist to the same or greater extent;

3. History of prior violations—The state agency shall consider whether or not the provider has been given notice of prior violations of this rule or other program policies. If the provider has received notice and has failed to correct the deficiencies or has resumed the deficient performance, a history shall be given substantial weight supporting the agency’s decision to invoke sanctions. If the history includes a prior imposition of sanction, the agency should not apply a lesser sanction in the second case, even if the subsequent violations are of a different nature;

4. Prior imposition of sanctions—The MO HealthNet agency shall consider more severe sanctions in cases where a provider has been subject to sanctions by the MO HealthNet program, any other governmental medical program, Medicare, or exclusion by any private medical insurance carriers for misconduct in billing or professional practice. Restricted or limited participation in compromise after being notified or a more severe sanction should be considered as a prior imposition of a sanction for the purpose of this subsection;

5. Prior provision of provider education—in cases where sanctions are being considered for billing deficiencies only, the MO HealthNet agency may mitigate its sanction if it determines that prior provider education was not provided. In cases where sanctions are being considered for billing deficiencies only and prior provider education has been given, prior provider education followed by a repetition of the same billing deficiencies shall weigh heavily in support of the medical agency’s decision to invoke severe sanctions; and

6. Actions taken or recommended by peer review groups, licensing boards, or Professional Review Organizations (PRO) or utilization review committee—Actions or recommendations by a provider’s peers shall be considered as serious if they involve a determination that the provider has kept or allowed to be kept, substandard medical records, negligently or carelessly performed treatment or services, or, in the case of licensing boards, placed the provider under restrictions or on probation.

(B) Where a provider has been convicted of defrauding any Medicaid program, has been previously sanctioned for program abuse, has been terminated from the Medicare program, the MO HealthNet agency shall terminate the provider from participation in the MO HealthNet program.

(C) When a sanction involving the collection, recoupment, or withholding of MO HealthNet payments from a provider is imposed on a provider, it shall become effective ten (10) days from the date of mailing or delivery of said notice, whichever occurs first. When any other sanction is imposed on a provider it shall become effective thirty (30) days from the date of mailing or delivery of a decision of the Department of Social Services or its designated division, whichever occurs first. If, in the judgment of the single state agency, the surrounding facts and circumstances clearly show that serious abuse or harm may result from delaying the imposition of a sanction, any sanction may be made effective three (3) days after mailing of the notice to the provider or immediately upon receipt of notice by the provider, whichever occurs first.

(D) A sanction may be applied to all known affiliates of a provider, provided that
7. Instruction on reimbursement rates; and

8. Instruction on how to inquire about coding or billing problems.

(K) Providers that have been suspended from the MO HealthNet program under subsections (4)(B) and (C) may be re-enrolled in the MO HealthNet program upon expiration of the period of suspension from the program after making satisfactory assurances of future compliance. Providers that have been terminated from the MO HealthNet program under subsection (4)(B) may be re-enrolled in the program at the sole discretion of the single state agency and only after providing satisfactory evidence that the past cause for termination has ceased and that future participation is warranted.

(6) Amounts Due the Department of Social Services From a Provider.

(A) If there exists an amount due the Department of Social Services from a provider, the single state agency shall notify the provider of the amount of the overpayment. Notice shall be mailed or delivered to the address on the provider's enrollment record. If the amount due is not sooner paid to the Department of Social Services by or on behalf of the provider, the single state agency may take appropriate action to collect the overpayment forty-five (45) days from the date of mailing or delivery of said notice, whichever occurs first. The single state agency may recover the overpayment by withholding from current MO HealthNet reimbursement. The withholding may be taken from one (1) or more payments until the funds withheld in the aggregate equal the amount due as stated in the notice.

(B) When a provider receives notice of an overpayment and the amount due is in excess of one thousand dollars ($1,000), the provider, within fourteen (14) days of the notice being mailed or delivered to the provider, whichever occurs first, may submit to the single state agency a plan for repayment of forty percent (40%) of the overpayment amount and request that the plan be adopted and adhered to by the single state agency in collecting the overpayment. No repayment plans will be considered for the first sixty percent (60%) of the overpayment amount. If this repayment plan is timely received from a provider, the single state agency shall consider the proposal, together with all the facts and circumstances of the case and reject, accept, or offer to accept a modified version of the other enrolled provider's plan for repayment. The single state agency shall notify the provider of its decision within ten (10) days after the proposal is received. If no plan for repayment is agreed upon within thirty (30) days from the date of mailing or delivery of a decision of the notice of the overpayment to the provider, whichever occurs first, the MO HealthNet agency may take appropriate action to collect the balance of the amount due.

(C) If a plan agreed to and implemented under provisions of subsection (6)(B) for repayment of amounts due the Department of Social Services from a provider is breached, discontinued, or otherwise violated by a provider, the single state agency, immediately upon the next payment to the provider, may begin to withhold payments or portions of payments until the entire amount due has been collected.

(D) Repayment or an agreement to repay amounts due the Department of Social Services from a provider may be suspended for any other provider when the other enrolled provider has received payment on behalf of the provider who incurred the overpayment (such as when a provider has directed payment to another enrolled provider). The single state agency may also collect provider overpayments from any other enrolled provider with the same federal employer identification number (EIN) as the provider who incurred the overpayment. The state agency shall notify the other enrolled provider(s) forty-five (45) days prior to initiating the overpayment action. The notice shall be mailed to the address on the provider's enrollment record. If the amount due is in excess of one thousand dollars ($1,000), the other enrolled provider, within fourteen (14) days of mailing of the notice, may submit to the single state agency a plan for repayment of forty percent (40%) of the overpayment amount and request that the plan be adopted and adhered to by the single state agency in collecting the overpayment. No repayment plan will be considered for the first sixty percent (60%) of the overpayment amount. If this repayment plan is timely received from the other enrolled provider, the single state agency shall consider the proposal, together with all the facts and circumstances of the case and reject, accept, or offer to accept a modified version of the other enrolled provider's plan for repayment. The single state agency shall notify the other enrolled provider of its decision within ten (10) days after the proposal is received. If no plan for repayment is agreed upon within thirty (30) days after the other enrolled provider receives notice of the overpayment, the Medicaid agency may take
appropriate action to collect the balance of the amount due.


13 CSR 70-3.050 Obtaining Information From Providers of Medical Services

PURPOSE: This rule provides the basis for examination of the records of any provider who expects to receive payment from the Division of Family Services and for maintaining the confidentiality of any of those records.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) Public Law 89-97, 1965 Amendment to the Social Security Act (42 U.S.C.A. Section 301), sections 201.151 and 208.153, RSMo, and other pertinent sections of Chapter 208, RSMo require Missouri to provide certain medical services to eligible individuals and further provide that these services may be obtained from any provider who has entered into an agreement for provision of medical services with the Missouri Division of Family Services. Therefore, to aid the Division of Family Services in determining the proper and correct payment for those services, the acceptance of these medical services and benefits by any applicant or recipient of public assistance benefits constitutes authorization for the Division of Family Services, or its duly authorized representative, to examine all records pertaining to medical services provided the applicant or recipient in order that proper payment for the services may be made to the provider of services.

(2) Section 208.155, RSMo, regarding the confidentiality of all information concerning applicants for or recipients of medical services shall be confidential, shall be strictly adhered to.


13 CSR 70-3.060 Medicaid Program Payment of Claims for Medicare Part B Services

(Resinded August 11, 1988)


13 CSR 70-3.100 Filing of Claims, MO HealthNet Program

PURPOSE: This rule establishes the general provisions for submission or resubmission of claims and adjustments of claims to MO HealthNet.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Claim forms used for filing MO HealthNet services as appropriate to the provider of services are—

(A) Nursing Home Claim—electronic claim submission software when authorized by the state's fiscal agent;

(B) Pharmacy Claim—MO-8803, Revision 11/00 or POS, on-line claim format—NCPPD current version or electronic claim submission;

(C) Outpatient Hospital Claim—UB-04 CMS-1450 or electronic claim submission;

(D) Professional Services Claim—CMS-1500, Revision 12/90, or electronic claim submission;

(E) Dental Claim—American Dental Association (ADA) 2002, 2004 revision, Dental Form or electronic claim submission; or

(F) Inpatient Hospital Claim—UB-04 CMS-1450 or electronic claim submission.

(2) Specific claims filing instructions are modified as necessary for efficient and effective administration of the program as required by federal or state law or regulation. Reference the appropriate MO HealthNet provider manual, provider bulletins, and claim filing.
## Rules of Department of Health and Senior Services

### Division 15—Division of Senior and Disability Services

### Chapter 7—Service Standards

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 CSR 15-7.005 Definitions</td>
<td>3</td>
</tr>
<tr>
<td>19 CSR 15-7.010 General Requirements for All Service Providers</td>
<td>4</td>
</tr>
<tr>
<td>19 CSR 15-7.021 In-Home Service Standards</td>
<td>6</td>
</tr>
<tr>
<td>19 CSR 15-7.040 Transportation Service Standards</td>
<td>12</td>
</tr>
<tr>
<td>19 CSR 15-7.050 Information and Assistance Service Standards</td>
<td>14</td>
</tr>
<tr>
<td>19 CSR 15-7.060 Nutrition Service Standards</td>
<td>15</td>
</tr>
</tbody>
</table>
Title 19—DEPARTMENT OF
HEALTH AND SENIOR SERVICES
Division 15—Division of Senior and
Disability Services
Chapter 7—Service Standards

19 CSR 15-7.005 Definitions

PURPOSE: This rule defines terms used in
this chapter.

(1) Access services—A category of services
which facilitates access to and utilization of
other services. Access services may include
transportation, outreach, case management,
and information and assistance.

(2) Assisted transportation—A service which
provides assistance, including escort, to a
person who has difficulties (physical or cog-
nitive) using regular vehicular transportation.

(3) Case management—A service which
ensures that individuals with chronic or acute
cares are assessed and provided with a
comprehensive and coordinated service pro-
gram designed to meet those assessed needs.

(4) Caterer—A restaurant, hospital, school
or commercial organization which prepares
meals under contract (usually a fixed price
per meal contract).

(5) Center—Any facility regardless of termi-
nology used, that is, senior center, congrue-
tate nutrition center, nutrition site, support-
ive services center, satellite center or site or
multipurpose senior center, that is utilized to
provide one (1) or more services to older
persons.

(6) Congregate nutrition services—The provi-
sion of nutrition services to older persons in
an approved center.

(7) Contributions—Money or food stamps
(for meals only) given voluntarily and confi-
dentially toward the cost of a service received.

(8) Division—The Division of Aging of the
Missouri Department of Social Services.

(9) Economic need, greatest—The need
resulting from an income level at or below the
poverty threshold established by the Office of
Management and Budget.

(10) Follow-up—Reconnecting the inquirer or
agency/organization to whom the referral was
made to assure if contact was made or if fur-
ther services are required.

(11) Frail elderly—Older persons having a
physical or mental disability, including hav-
ing Alzheimer’s disease or a related disorder
with neurological or organic brain dysfunc-
tion, that restricts the ability of the individu-
al to perform normal daily tasks or which
threatens the capacity of the individual to live
independently.

(12) Home and community services—ser-
vice offered to eligible adults in a non-institu-
tional setting.

(13) Homebound—One who is confined to
the home because of illness or incapacitating
disability.

(14) Home-delivered nutrition services—
Nutrition services delivered to homebound or
otherwise isolated recipients in their homes.

(15) Information and assistance—Providing a
prompt, accurate and pertinent response to an
inquiry, which may include directing the per-
son to the appropriate resource.

(16) Low-income—Persons whose annual
income is at or below the poverty threshold
established by the Office of Management and
Budget.

(17) Meal pattern—A meal consisting of
two (2) or three (3) kinds of vegetables and
fruits to total one (1) cup serving, one (1)
serving of enriched or whole grain bread or
alternate, one (1) teaspoon of butter or forti-
fied margarine, one-half (1/2) cup dessert
and one (1) cup of milk.

(18) Minority—Individuals of the following
racial/ethnic compositions: American Indian/
Alaskan Native; Asian/Pacific Islander;
Black, not of Hispanic origin; or Hispanic.

(19) Multipurpose senior center—A commu-
nity or neighborhood facility for the organi-
zation and provision of a broad spectrum of
services which shall include, but not be lim-
ited to, provision of health, including mental
health, social, nutrition and educational ser-
vices and the provision of facilities for recrea-
tional activities for older persons.

(20) Nutrition services—Provision of congre-
gate or home-delivered meals, or both.

(21) Older person—A person sixty (60) years
of age or older.

(22) Outreach—A service within the access
category involving a first time individualized
face-to-face contact initiated by the area agen-
cy or service provider to identify the un-
served elderly population, inform them of
available community resources and, if appro-
priate, assist them in gaining access to needed
services.

(23) Potentially hazardous food—Any perish-
able food which consists in whole or in part
of milk or milk products, eggs, meat, poultry,
fish, shellfish or other ingredients in a form
capable of supporting rapid and progressive
growth of infectious or toxigenic microorgan-
isms. The term does not include foods which
have a pH level of four and six-tenths (4.6) or
below.

(24) Principles of menu planning—Planning
menus to provide variety in food selection,
preparation, texture, shape and size of food
and compatibility in food flavors and colors.

(25) Public information—Provision of infor-
mation to the public where seniors gain
access to area agency services or the informa-
tion meets a need of the elderly.

(26) Senior center—A facility providing
nutrition services and a variety of supportive
services to older persons.

(27) Service provider—Any agency which
contracts with the Missouri Division of
Aging or an Area Agency on Aging to pro-
sure services directly to older persons.

(28) Service recipient—An eligible individu-
al who receives one (1) or more services.

(29) Social need, greatest—The need caused
by noneconomic factors which include physi-

cal and mental disabilities, language barriers,
and cultural, social or geographical isolation
including that caused by racial or ethnic sta-
tus which restricts an individual's ability to
perform normal daily tasks or which threat-
ens the capacity to live independently.

(30) Supportive program—A set of services
consisting, at a minimum, of the categories of
access, in-home, legal and ombudsman.

(31) Supportive service center—A facility
providing only activities and supportive ser-
vices, but no nutrition services.

(32) Volunteer—A person, other than staff or
Senior Community Service Employment Pro-
gram (SCSEP) enrollees, who contributes
personal service.
19 CSR 15-7.010 General Requirements for All Service Providers

PURPOSE: This rule describes the general requirements that all service providers shall meet to receive grants or subgrants to provide services for older persons or low-income handicapped adults funded by the division or area agencies.

(1) Service providers shall meet all applicable state and local licensure and safety requirements for the provision of those particular services.

(2) Service providers shall maintain any licensure, certification or registration mandated by any state or local government, body or board.

(3) Service providers shall allow only employees or volunteers holding a current license, certification or registration to perform those tasks, duties or functions for which licensure, certification or registration is required by any state or local agency, body or board.

(4) Service providers shall have an adequate number of staff (paid or volunteer) who are qualified to perform assigned functions in order to implement the activities and services.

(A) Multilingual staff shall be available when there are substantial numbers of non-English speaking service recipients.

(B) A written job description for each position function and responsibility and the line of supervisory authority for each position (paid and volunteer) shall be developed and maintained. Personnel qualifications shall meet job description requirements.

(C) A written performance evaluation of each paid staff member shall be done at least annually and shall be maintained in the employee’s personnel file.

(D) A training file shall be maintained that documents the type of training provided, names of staff and volunteers participating, number of hours of training provided and date(s) training was provided. A report of each employee’s orientation and in-service training provided by the service provider and from other sources shall be placed in that employee’s personnel file.

(5) Centers shall be in compliance with all applicable state and local fire and safety laws, as well as the following requirements:

(A) If the division determines that the state or local fire safety laws, ordinances or codes are not adequate to assure the safety of older persons or for any locality that has no governing fire and safety laws, ordinances or codes, the provisions of the National Fire Protection Association Life Safety Code (NFPA No. 101, 1981 edition) for places of assembly shall apply.

(B) Centers shall have installed and shall maintain in operable condition an adequate number of smoke detectors and fire extinguishers of the appropriate type as determined by consultation with state or local fire authorities. All smoke detectors and fire extinguishers shall be located within the premises according to the recommendations of state or local fire authorities;

(C) Centers shall develop a written safety and evacuation plan for assuring the safety of service recipients, staff and volunteers in case of fire or other hazardous situations and evacuation drills shall be conducted periodically. Copies of the plan shall be on file at the center and at the area agency’s office and a charted plan shall be posted conspicuously in the center. The plan and procedures shall include, but need not necessarily be limited to:

1. A written assessment of potential fire or safety hazards present on the premises and actions and procedures that are to be followed to minimize danger;

2. A written schedule for periodic check of smoke detectors and fire extinguishers to assure that adequate pressure or battery strength is maintained for efficient operation when needed; and

3. A written training plan including frequency of comprehensive and refresher training for staff and volunteers on safety responsibilities and actions to be taken if an emergency situation occurs with documentation of training sessions provided; and

(D) Fire inspections shall be conducted annually at all centers. At least every two (2) years the inspection shall be conducted by state or local fire authorities; on alternate years the area agency may conduct the inspection provided appropriate training has been received and the form required by the division is used. Documentation of the inspector’s report, recommendations and corrections of any deficiencies shall be kept at both the area agency and center offices.

(6) Service providers whose staff have direct physical contact with service recipients shall make emergency arrangements in consultation with relevant agencies, for dealing with service recipient personal emergencies, that include:

(A) Specific personnel designated and trained to take charge in an emergency;

(B) A person, present or immediately available during all hours that the center is open, who has successfully completed a training course in first aid or emergency care that included at least:

1. Basic first aid;

2. Cardiopulmonary resuscitation (CPR);

3. Heimlich maneuver; and

4. Guidelines on when to attempt first aid or when to take alternative action; and

(C) Written instructions posted conspicuously by each telephone which includes the 911 emergency telephone number, if available; or other local emergency telephone numbers, such as those of physicians, ambulances, hospital emergency rooms and local civil defense or disaster offices if the 911 number is not available in the community.

(7) Caterers and centers in which food is prepared, served, or both, shall be maintained in a safe and sanitary manner and shall be in compliance with all applicable state, county or city health codes. Each location at which food is prepared shall be inspected annually by state or local health authorities. Each location at which prepared food is received from another source shall be inspected annually. The inspection shall be conducted by state or local health authorities at least every two (2) years; on alternate years the area agency may conduct the inspection provided appropriate training has been received and the form required by the division is used. Documentation of the inspector’s report, recommendations and corrections of any deficiencies shall be kept at both the area agency and center offices.

(8) Service provider staff and volunteers shall be familiar with and shall be able to recognize situations of possible abuse, neglect, exploitation or likelihood of serious physical harm involving older persons. Conditions or circumstances which place the older person or the household in likelihood of serious physical harm shall be immediately reported to the division’s elderly abuse hotline (1-800-392-0210). Likelihood of serious physical harm means one of the following:
(A) A substantial risk that physical harm to an adult will occur because of failure or inability to provide for essential human needs as evidenced by acts or behavior which have caused harm or which give another person probable cause to believe that the adult will sustain harm;

(B) A substantial risk that physical harm will be inflicted by an eligible adult upon him/herself, as evidenced by recent credible threats, acts or behavior which have caused harm or which places another person in reasonable fear that the eligible adult will sustain harm;

(C) A substantial risk that physical harm will be inflicted by an eligible adult upon another as evidenced by recent acts or behavior which has caused harm or which gives another person probable cause to believe the eligible adult will sustain harm; or

(D) A substantial risk that further physical harm will occur to an eligible adult who has suffered physical injury, neglect, sexual or emotional abuse or other maltreatment or wasting of his/her financial resources by another person.

(9) Service providers shall provide the following:

(A) Public information and education activities to ensure that older persons are informed of the services available and have maximum opportunity for participation;

(B) Coordination with other service providers in the planning and service area to assure comprehensive delivery of services and reduce duplication; and

(C) A written complaint procedure through which the service recipient can communicate to the service provider aspects of the service which impact negatively upon them.

(10) Service providers who use volunteers shall develop a written plan for recruiting, orienting, training, supervising and terminating volunteers.

(11) Service providers shall serve older persons with the greatest economic or social need, especially low-income minority persons. Service providers may use methods such as location of services and specialization in the types of services most needed by these groups to meet this requirement. Service providers shall not use a means test to deny individuals services within the target population.

(12) Service providers shall obtain the views of service recipients about the services they receive.

(13) Service providers shall assure that federal funds shall not be used to replace funds from nonfederal sources and that the service provider shall continue or initiate efforts to obtain support from private sources or other public organizations.

(14) Service providers shall implement the provisions of the Americans with Disabilities Act (ADA) of 1990 (PL 101-336) which prohibits discrimination against people with disabilities, to include:

(A) Operation of programs, services, and activities in such a manner as to be readily accessible to and usable by persons with disabilities;

(B) Senior centers are considered places of public accommodation and must therefore comply with the ADA. The responsibility to remove barriers in existing buildings is an ongoing process and area agencies should use the following priorities as a guide to increase accessibility: 1) access to the facility; 2) access to the area in which goods and services are available; 3) access to restrooms facilities; and 4) removing any remaining barriers. Area agencies offering services in buildings where barrier removal is not readily achievable must develop a written implementation plan designed to achieve compliance, as well as a written policy outlining alternative methods to provide services during the interim. All renovations, alterations or new construction must ensure compliance with ADA requirements by using the ADA Standards for Accessible Design published in Appendix A to the Department of Justice Title III regulations, 28 CFR part 36; and

(C) Reasonable accommodation shall be made in policies, practices, and procedures to allow participation of persons with disabilities. To the greatest extent possible, services should be provided in an integrated setting; however, when barriers cannot be removed, alternative methods of providing the services, programs, and activities must be offered.

(15) Procedures for handling contributions shall be developed and implemented that include the following:

(A) Each recipient shall be provided with an opportunity to voluntarily contribute to the cost of the service;

(B) The privacy of each recipient with respect to his/her contribution shall be protected;

(C) Establish and implement a system of internal control that ensures all contributions received are fully and accurately recorded, deposited, accounted for, and reported to the area agency.

1. Collecting contributions in a locked box at senior centers;

2. Using two (2) persons when accessing contributions or to count receipts;

3. Keeping receipts in a secure area or locked box until deposited;

4. Recording all contributions on the date of receipt;

5. Taking precautions to prevent theft of cash receipts;

6. Reporting contribution receipts to the area agency at least monthly; and

7. Avoiding an accumulation of a large balance of income on hand;

(D) All contributions shall be used to expand the service for which the contribution was made. Nutrition services contributions shall be used to increase the number of meals served to facilitate access to meals and to provide supportive services directly related to nutrition services;

(E) A suggested contribution schedule may be developed for each service provided. In developing a contribution schedule, the provider shall consider the income ranges of elderly persons in the community, the provider’s other source of income and the actual cost of the service. The contribution schedule should be revised periodically as needed; and

(F) A provider shall not deny any elderly person a service because the elderly person will not or cannot contribute to the cost of the service. An eligible service recipient shall not be charged for participating in any service or activity.

(16) Administrative policies and procedures shall be followed which include:


(B) Record keeping and confidentiality as cited in 13 CSR 15-4.300;

(C) Reporting systems to document and report all required program, fiscal and administrative information needed by the area agency. The system shall include format and timelines for submission and the following records:

1. Documentation of the total unduplicated low-income minority persons receiving services;

2. Records of paid staff time and volunteer time; and

3. Documentation of service recipient eligibility;

(D) Bonding for all volunteers, staff or governing body members who have fiscal
responsibilities, to protect against loss of federal and state funds or agency income:

(G) Insurance coverage which includes:

1. Workers' Compensation—statutory amount as prescribed by the laws of Missouri;
2. Comprehensive general liability covering employees, volunteers and service recipients;
3. Product liability as applicable to the service provided; and
4. Automobile liability for service provider vehicles and, for volunteers using their own vehicles, at least a procedure for verifying that the volunteer maintains adequate insurance and understands his/her liability;

(F) Written policies that specify which holidays and special event days may be observed by curtailing delivery of services and procedures for publicizing these dates and assuring that service recipients are informed;

(G) Written policies and procedures to be followed when service delivery must be interrupted due to emergency situations including:
1. Definition of types of emergencies (weather, natural disaster, health, and the like);
2. Specifications of the person/position responsible for making the decision to interrupt scheduled service delivery; and
3. Identification of procedures to be followed for notifying service recipients; and

(H) Written policies and procedures to be followed when it is necessary to terminate or deny services to an individual service recipient that include:
1. Justification for termination or denial;
2. Referral to other needed services; and
3. Follow-up for return to service, when appropriate.

(17) Any facility altered, renovated, acquired by purchase or lease or constructed using federal or state funds may not be used for religious instruction or as a place of worship, as follows:

(A) Federal and state funds shall not be used to renovate, alter or construct a building that is also intended to be used, or is used, as a place of worship even though the building may serve as a multipurpose senior center;

(B) Service providers shall have a written agreement with sectarian organizations housing alternative services programs which includes the provision that all equipment purchased with federal funds remain the property of the area agency, as per 45 CFR part 74;

(C) Each individual participant shall have a free choice of whether or not they wish to participate in prayer and no staff (paid or vol-
unteer for that day) shall initiate, lead, organize or encourage a prayer or moment of silence; and

(D) Service providers shall ensure that no federal or state funds shall be used for religious instruction or worship.

(18) Any facility altered, renovated, acquired by purchase or lease or constructed using federal or state funds may not be used for political campaigning on behalf of any candidate for local, state or national office unless—

(A) The political discussion is a planned, scheduled activity;

(B) All candidates for a particular office are given an equal opportunity or afforded the opportunity to be present; and

(C) All candidates are afforded the opportunity to present their views through a series of discussions, scheduled at intervals, but given equal time.


19 CSR 15-7.021 In-Home Service Standards

PURPOSE: This rule sets forth standards to be met by any agency which contracts with the Missouri Department of Health and Senior Services, Division of Senior and Disability Services for provision of in-home services.

(1) The Department of Health and Senior Services (also referred to as the department), Division of Senior and Disability Services (also referred to as the division) payment to the provider is made on behalf of an eligible client as an act of indirect or third-party reimbursement and is not made as a payment for the purchase of a service. Only those services authorized by the division shall be reimbursable to the provider.

(2) The in-home service provider shall deliver services in compliance with the standards set forth in this rule and 13 CSR 70-91.010 Personal Care Program, 13 CSR 70-3.020 Title XIX Provider Enrollment, and 13 CSR 70-3.030 Sanctions for False and Fraudulent Claims for Title XIX Services.

(3) Failure of the in-home service provider to comply with the terms of the contract and these standards may constitute a breach of contract.

(4) In accordance with the protective service mandate (Chapter 660, RSMo), the division may take immediate action to protect clients from providers who are found to be out of compliance with the requirements of this rule and of any other rule applicable to the in-home services program, when such noncompliance is determined by the division to create a risk of injury or harm to clients.

(A) Evidence of such risk may include:
1. Unreliable, inadequate, falsified, or fraudulent documentation of service delivery or training;
2. Failure to deliver services in a reliable and dependable manner;
3. Use of in-home service workers who do not meet the minimum employment requirements or training standards of this rule;
4. Failure to comply with the requirements for background screening of employees (sections 660.315, RSMo and 660.317, RSMo); or
5. Discontinuing services outside the provisions specified in section (16) of this rule without the knowledge and consent of the client for a period of one (1) week or three (3) consecutive scheduled service delivery dates, whichever is shorter.

(B) Immediate action may include, but is not limited to:
1. Removing the provider from any list of providers, and for clients who request the unsafe and noncompliant provider, informing the clients of the determination of noncompliance after which any informed choice will be honored by the division;
2. Informing current clients served by the provider of the provider's noncompliance and that the division has determined the provider unable to deliver safe care; such clients will be allowed to choose a different provider from the list maintained by the division which will then be immediately authorized to provide service to them.

(5) The division will not consider any proposal for an in-home services contract and subsequent enrollment as a Medicaid personal care provider under 13 CSR 70-91.010(3), unless the proposal is fully completed, properly attested to or affirmed by a person with
the expressed authority to sign the proposal, and contains all required attachments.
(A) The proposal shall be made in the exact legal name of the applicant for a contract. The attachments to the proposal shall include, but are not limited to the following information/copies:
1. Federal tax identification number;
2. Most recent corporate annual registration report filed with the Missouri secretary of state (if applicable);
3. Certificate of Good Standing issued by the Missouri secretary of state (if applicable);
4. Fictitious name registration filed with the Missouri secretary of state (if applicable);
5. Corporation by-laws, if the applicant is a corporation;
6. Operating agreement and management agreement, if applicable, if the provider is a limited liability company; and
7. Certificate of Insurance evidencing the coverage described in subsection (18)(F) of this rule, naming the division as a certificate holder.
(B) Upon receipt of a proposal, the division will conduct whatever investigation which, in the division’s discretion, is necessary to determine the applicant’s eligibility for a contract. The decision determining eligibility for a contract may include, but is not limited to, the conduct of the provider and principals of the provider during any prior contractual periods.
(C) Prior to the issuance of an initial contract, a site visit will be conducted for in-home service providers entering the program after July 1, 2001.

(6) Respite care services are maintenance and supervisory services provided to a client in the individual’s residence to provide temporary relief to the caregiver(s) that normally provides the care.

(A) Respite care services shall include, at a minimum, the following activities:
1. Supervision—The respite care worker will provide personal oversight of the client for the duration of the service period. Personal oversight includes making a reasonable effort to assure the safety of the client and to assist the client in meeting his/her own essential human needs. Sleeping is permitted when the client is asleep, provided there is no indication that the condition of the client would pose a risk if the client awoke while the respite care worker was sleeping. The worker must be in close proximity to the client during a sleeping period;
2. Companionship—The worker will provide companionship during the client’s waking hours and attempt to make the client as comfortable as possible; and
3. Direct client assistance—The worker will provide direct client assistance as needed to meet needs usually provided by the regular caregiver.

(B) Basic respite care services are provided to clients with non-skilled needs.

(C) Advanced respite care services are maintenance and supervisory services provided to a client with non-skilled needs that require specialized training.
1. Clients appropriate for this service include persons with special needs, requiring a higher level of personal oversight as determined by the division.
2. An initial on-site evaluation of the client’s condition and identification of special training needs for the advanced respite care worker shall be made by the provider RN prior to initiation of service.
3. A monthly nurse visit will be authorized for each advanced respite care client for each month advanced respite care is authorized. During the visit the nurse will evaluate and document the client’s condition and adequacy of the care plan.

4. Although monthly visits may be performed by a licensed nurse, for clients receiving ongoing advanced respite care services, it is required that the on-site visit be conducted by an RN at six (6) month intervals.

(D) Nurse respite care services are maintenance and supervisory services provided to a client with special skills needs. Nurse respite care services are provided to relieve a caregiver who lives with the client.
1. Clients appropriate for this service include persons with special needs as determined by the division.
2. An initial on-site evaluation of the client’s condition and identification of special training needs for the nurse respite care worker shall be made by the provider RN prior to initiation of service.
3. For clients receiving ongoing nurse respite care services, it is required that an on-site evaluation be conducted by an RN at six (6) month intervals. The RN evaluation shall document the client’s condition and the adequacy of the care plan.

(7) Homemaker services are general household activities provided by a trained homemaker when the client is unable to manage the home and care for him/herself or others in the home or when the individual (other than the client) who is regularly responsible for these activities is temporarily absent. Homemaker services shall include, at a minimum, the following activities:

(A) Plan and prepare meals, including special diet menus and perform cleanup after meals;
(B) Wash dishes, pots, pans and utensils;
(C) Clean kitchen counters, cupboards and appliances, including oven, surface burners and inside refrigerator;
(D) Clean bathroom fixtures;
(E) Make beds and change sheets;
(F) Sweep, vacuum and scrub floors;
(G) Tidy and dust the home;
(H) Launder clothes and linens;
(I) Iron and mend clothes;
(J) Wash inside windows and clean blinds that are within reach without climbing;
(K) Bag trash inside the home and put it out for pick up;
(L) Shop for essential items (for example, groceries, cleaning supplies, etc.);
(M) Perform essential errands (for example, pick up medication, post mail, etc.);
(N) Read and write essential correspondence for blind, iliterate or physically impaired clients; and
(O) Instruct the client in ways to become self-sufficient in performing household tasks.

(8) Chore services are short-term, intermittent tasks necessary to maintain a clean, safe, sanitary and habitable home environment and determined by the division to be critical in maintaining the client’s health and safety. Chore services shall be provided only when the client or other household member is incapable of performing or financially providing for them, and when no other relative, caregiver, landlord, community or volunteer agency, or third party payor is capable of or responsible for providing such tasks. Chore services include the following activities:

(A) Wash walls and woodwork;
(B) Clean closets, basements and attics;
(C) Shampoo rugs;
(D) Air mattresses and bedding;
(E) Spray for insects within the home with over-the-counter supplies; and
(F) Provide rodent control within the home (for example, setting traps and putting out over-the-counter supplies).

(9) The range of homemaker, chore, and respite activities the in-home worker provides is mutually determined by the provider agency and the client.

(10) Basic personal care services are maintenance services provided to a client in the individual’s residence to assist with the activities of daily living. Regulations for personal care are filed at 13 CSR 70-91.010.
(11) Advanced personal care services are maintenance services provided to a recipient in the individual's home to assist with activities of daily living when this assistance requires devices and procedures related to altered body functions. Regulations for advanced personal care are filed at 13 CSR 70-91.010.

(12) Authorized nurse visits are skilled nursing services of a maintenance or preventive nature provided to clients with stable chronic conditions. They are provided at the client’s residence and prior-authorized by the division case manager. These services are not intended primarily as treatment for an acute health condition. Authorized nurse visit services may be provided by a licensed practical nurse (LPN) under the direction of a registered nurse (RN). Regulations for authorized nurse visits are filed at 13 CSR 70-91.010.

(13) The in-home service provider shall not perform and shall not be reimbursed for the following activities:

   (A) Providing therapeutic/health-related activities that should be performed by a registered nurse, licensed practical nurse or home health aide under Titles XVIII or XIX home health programs;
   (B) Providing transportation services;
   (C) Administering over-the-counter or prescribed medications;
   (D) Performing household services not essential to the client’s needs; and
   (E) Providing friendly visiting.

(14) Prior to approval by the division for an in-home services contract and subsequent enrollment as a Medicaid personal care provider under 13 CSR 70-91.010(3), in addition to the contract, after August 1, 1998, all providers must—

   (A) Designate to the division the manager who will be responsible for the provider’s day-to-day operation. This manager shall be a policy maker and direct the provider’s record keeping, service delivery verification, hiring and firing practices and staff training;
   (B) Ensure that the designated manager successfully completes (or has completed) a division provider certification course offered (quarterly or as needed) at no charge. Attendees shall be responsible for their own expenses, including but not limited to travel, meal and lodging costs they may incur in attending this course;
   (C) Be responsible for maintaining documentation of attendance and requiring attendance by new managers within six (6) months of hire; and
   (D) Ensure the designated managers annually attend division sponsored training designed to update certified managers.

(15) Clients shall be accepted for care on the basis of a reasonable expectation that the client’s maintenance care needs can be met adequately by the agency in the client’s place of residence. Services shall follow a written state-approved care plan developed in collaboration with and signed by the client.

   (A) The care plan shall consist of an identification of the services and tasks to be provided, frequency of services, the maximum number of units of service per month, functional limitations of the client, nutritional requirements if a special diet is necessary, medications and treatments as appropriate, any safety measures necessary to protect against injury and any other appropriate items.
   (B) A new in-home assessment and care plan may be completed by the division as needed to redefine the need for in-home services or to adjust the monthly amount of authorized units. In collaboration with the client, the provider agency may develop a new or revised set of service tasks, and weekly schedule for service delivery which shall be forwarded to the division. The service provider must always have, and provide services in accordance with, a current care plan. Only the division, not the service provider, may increase the maximum number of units for which the individual is eligible per month.
   (C) The client will be informed of the option of services available to him/her in accordance with the assessment findings.

(16) To ensure safety and welfare of clients, the following policies and procedures shall be followed when discontinuing in-home services:

   (A) Services for a client shall be immediately discontinued by a provider upon receipt of information that the client’s case is closed by the division;
   (B) When the provider learns of circumstances that may require closing the case (for example, death, entry into a nursing home, client no longer needs services, etc.), the provider shall immediately notify the division case manager in writing and request that the client’s service be discontinued;
   (C) When the client, family member, or other person living in the household, threatens or abuses provider personnel, the provider shall immediately notify the division case manager by telephone and in writing including information regarding the threat or abusive acts. The division and provider shall mutually determine appropriate intervention and the feasibility of continuing services. The division shall discontinue the client’s services, and may refer the client to other programs that could meet the client’s needs, when the division has determined that it is no longer appropriate for any in-home services provider to continue to provide services to the client due to threats or abuse of provider or division personnel;
   (D) When a client is noncompliant with the agreed upon care plan or the provider is unable to continue to meet the needs of a client still in need of assistance, the provider shall contact the division case manager and client (including the caregiver or family when appropriate). The provider shall give written notice of discharge to the client or client’s family and the division case manager at least twenty-one (21) days prior to the date of discharge. During this twenty-one (21)-day period, the division case manager shall make appropriate arrangements with the client for transfer to another agency, or arrange for care in another care setting. The provider must continue to provide care in accordance with the care plan for these twenty-one (21) days or until alternate arrangements can be made by the case manager, whichever comes first.

(17) Unless otherwise specified below, a unit of in-home service is fifteen (15) minutes of direct service provided to the client in the client’s home by a trained in-home service worker, including time spent on completing documentation of service units provided and obtaining the client’s signature. No units are reimbursed except as authorized by the division.

   (A) Time spent for travel, lunch, breaks or administrative activities, such as completing other reports or paperwork, shall not be included.
   (B) For monthly invoicing purposes, partial units of a particular service provided in the course of the month may be accumulated over the billing cycle; partial units shall not be accumulated or carried over to the next month’s billing cycle.
   (C) Advanced respite care is authorized in fifteen (15)-minute units, six to eight (6-8)-hour units, and seventeen (17) to twenty-four (24)-hour units.
   (D) Nurse respite care is authorized in fifteen (15)-minute units, with a minimum of sixteen (16) units per visit.
   (E) The monthly invoice submitted to the division for in-home service shall not exceed actual delivered units of services.
(18) The in-home service provider shall meet, at a minimum, the following administrative requirements:

(A) Employ and train the staff necessary to provide the required services and make staff available to serve in all sections of the provider's designated service area;

(B) Successfully contact at least two (2) credible references for each employee within thirty (30) calendar days of the date of employment. The term "credible" references shall mean former employers or other knowledgeable persons, excluding relatives of the employee. The documentation shall include the name of the employer and the individual giving the reference, the date, the response given when the reference was obtained by telephone and the signature of the person receiving the reference;

(C) Maintain a current copy of the department's Employee Disqualification List to ensure that no current or prospective employee's name appears on the list and discharge any such employee once it is discovered by the provider that the employee is on the Employee Disqualification List;

(D) Have the capability to provide service outside of regular business hours, on weekends and on holidays as authorized by the division;

(E) Protect the department and its employees, agents or representatives from any and all liability, loss, damage, cost and expense which may accrue or be sustained by the department, its officers, agents or employees as a result of claims, demands, costs, suits or judgments against it arising from the loss, injury, destruction or damage, either to person or property, sustained in connection with the performance of the in-home service;

(F) Maintain a commercial general liability insurance policy in full force and effect that covers all places of business and any and all clients, customers, employees and volunteers. Such policy shall be an occurrence policy and shall provide coverage for no less than one (1) million dollars per event and three (3) million dollars aggregate and shall include coverage for negligent acts and omissions of the provider's employees and volunteers in the provision of services to clients in such clients' homes. Such policy shall name the division as a certificated holder. Providers shall also maintain a professional liability insurance policy in full force and effect that covers all places of business and any and all clients, customers, employees and volunteers. Such policy shall provide coverage for no less than one (1) million dollars per event and three (3) million dollars aggregate and shall include coverage for negligent acts and omissions of the provider's employees and/or volunteers in the provision of professional services to clients in such clients' homes. Such policy shall name the division as a certificated holder. The policies shall be coordinated to ensure coverage for all negligent acts and omissions in the provision of the in-home services described in this rule and in 13 CSR 70-91.010, by the provider's employees and volunteers. Additionally, providers shall maintain an employer dishonesty bond covering employees and volunteers who are connected with the delivery and performance of in-home services in the client's home;

(G) Furnish adequate identification (ID) to employees of the provider. This ID shall be carried by the employee in a way that the client can see the name of the agency with whom the aide is employed. A permanent ID including the provider's name, employee's name and title shall be considered adequate ID. At the time of employment, an ID shall be issued which will meet the ID requirement. The provider shall require the return of the ID from each employee upon termination of employment;

(H) Ensure that no in-home services worker is a member of the immediate family of the client being served by that worker. An immediate family member is defined as a parent; sibling; child by blood, adoption, or marriage; spouse; grandparent or grandchild;

(I) Notify the division's central office of any changes in location, telephone number, administrative or corporate status;

(J) Have and enforce a written code of ethics which is distributed to all employees and clients. The code of ethics shall allow use of the bathroom facilities, and, with the client's consent, allow the worker to eat the lunch provided by the worker, in the client's home. The code of ethics shall be reviewed with the client, caregiver or family when appropriate, and include, at a minimum, the following prohibitions:

1. Use of client's car;

2. Consumption of client's food or drink (except water);

3. Use of client's telephone for personal calls;

4. Discussion of own or other's personal problems, religious or political beliefs with the client;

5. Acceptance of gifts or tips;

6. Bringing other persons to the client's home;

7. Consumption of alcoholic beverages, or use of medicine or drugs for any purpose, other than medical, in the client's home or prior to service delivery;

8. Smoking in client's home;

9. Solicitation or acceptance of money or goods for personal gain from the client;

10. Breach of the client's privacy and confidentiality of information and records;

11. Purchase of any item from the client even at fair market value;

12. Assuming control of the financial or personal affairs, or both, of the client or of his/her estate including power of attorney, conservatorship or guardianship;

13. Taking anything from the client's home; and

14. Committing any act of abuse, neglect or exploitation;

(K) Ensure prompt initiation of authorized services to new clients. The provider shall deliver the in-home service within seven (7) calendar days of receipt of the service authorization from the division case manager or on the beginning date specified by the authorization, whichever is later, and on a regular basis after that in accordance with the care plan. The date of receipt must be recorded on each service authorization by the provider. Verbal authorization shall be effective upon acceptance by the provider and services must begin as agreed. If service is not initiated within the required time period, detailed written justification must be sent to the division case manager with a copy maintained in the client's file;

(L) Recommend, verbally or in writing, changes to the authorized care plan any time the client has an ongoing need for service activities which may require more or fewer units than the amount specified in the care plan;

(M) Keep documentation of undelivered services, including the reason for this failure to deliver authorized units;

(N) Be aware that in-home services provided shall not be reimbursed unless authorized in writing by the division;

(O) Ensure that all subcontractors comply with all standards required by section (2) of this rule;

(P) Shall give a written statement of the client's rights and review the statement with each client and primary caregiver, when appropriate at the time service is initiated. The statement of client rights must contain at a minimum, the right to:

1. Be treated with respect and dignity;

2. Have all personal and medical information kept confidential;

3. Have direction over the services provided, to the degree possible, within the care plan authorized;

4. Know the provider's established grievance procedure and how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution;
5. Receive service without regard to race, creed, color, age, sex or national origin; and

6. Receive a copy of the provider’s code of ethics under which services are provided;

(Q) Have a system through which clients may present grievances concerning the operation of the in-home service program and/or delivery of care;

(R) Report all instances of potential abuse, neglect, exploitation of a client, or any combination of these, to the division’s Elder Abuse Hotline (1-800-392-0210), including all instances which may involve an employee of the provider agency;

(S) Copayment, as determined by the division’s case manager, shall be collected monthly from non-Medicaid clients. Liability levels for copayment are based on a sliding fee schedule as determined by the division. The money collected as copayment replaces the amount withheld from reimbursement by the automated payment system. Prompt and reasonable attempts to collect from the client, the client’s guardian or estate shall be made by the provider. Failure of clients to submit the required copayment, when determined to be a condition of participation, shall be reported to the division. Failure of clients to comply with copayment requirements may result in termination of services. Unsuccessful attempts to collect from the estate of a deceased client are to be referred to the home and community services deputy director of the division;

(T) Implement a contribution system which accounts for contributions received from clients for in-home services. Non-Medicaid clients shall be informed of their right to voluntarily contribute when they are admitted for services. Services shall not be denied to any client based on failure to make a contribution. Only the division may authorize expenditure of contributed funds, which shall be used for the sole purpose of providing in-home services. Reports of contributions by county shall be made to each home and community services regional manager including the balance on hand, contributions received, contributions used for division authorized services, and ending balance. The provider shall submit to the regional manager a contribution report at the end of any month in which contributions are received and/or expended. Upon termination or lapse of a provider’s contract, the remaining balance of all contribution funds held by the provider shall be reported to the division and will be withheld from the provider’s final reimbursement;

(U) Understand that both program and fiscal monitoring of the in-home service program shall be conducted by the division or its designee.

1. Monitoring visits may be announced or unannounced.

2. The division shall disclose the findings of the visit to the provider.

3. Upon request by the division, the provider shall submit a written plan for correcting areas found to be out of compliance:

(V) Designate trainer(s) to perform the sessions required as part of the basic training. The designated trainer(s) may be the RN, LPN, supervisor, or an experienced aide who has been employed by the provider agency at least six (6) months. A list of designated trainers must be available for monitoring;

(W) Providers must establish, enforce and implement a policy whereby all contents of the personnel files of its employees are made available to department employees or representatives when requested as part of an official investigation of abuse, neglect, financial exploitation, misappropriation of client’s funds or property, or falsification of documentation which verifies service delivery;

(X) Have established policies to promote the safety of its employees. The provider shall make available to its employees information about and access to public information sources to determine whether a client, family member, or other person living in the household may pose a potential danger to its employees. Public information includes, but is not limited to, the Missouri State Highway Patrol’s Sex Offender Registry and the Missouri State Courts Automated Case Management System. If an employee has a reasonable belief that a client, family member, or other person living in the household poses a potential danger to the employee, the provider shall document all necessary steps taken to protect the employee, which may include but is not limited to:

1. Obtaining a signed agreement from the client, family member, or other person living in the household not to engage in inappropriate activity involving the provider’s employees;

2. Seeking approval from the division to send two (2) provider employees for service delivery;

3. Requiring that a third party approved by the provider, the division, and the client or client’s designee be present on-site while the employee is on the premises;

(Y) The provider shall not harass, dismiss, or retaliate against an employee because the employee declines to provide services to a client based on the employee’s reasonable belief that such client, family member, or other person living in the household poses a danger to the employee; and

(z) The provider shall notify employees and implement established safety procedures upon receipt of information from the division or any other reliable source that a client, family member, or other person living in the household may pose a potential danger to provider employees.

(19) In-home service providers shall meet, at a minimum, the following personnel requirements:

(A) The in-home provider shall employ an RN or designate an RN as a consultant, who meets each of the following qualifications:

1. Currently licensed in Missouri;

2. Have at least one (1) year verifiable experience with direct care of the elderly, disabled, or infirm;

3. Meet the RN supervisory requirements for personal care and advanced personal care in accordance with 13 CSR 70-91.010;

(B) A supervisor shall be designated by the provider to supervise the day-to-day delivery of in-home service who shall be at least twenty-one (21) years of age and meet at least one (1) of the following requirements:

1. Be a registered nurse who is currently licensed in Missouri; or

2. Possess a baccalaureate degree; or

3. Be a licensed practical nurse who is currently licensed in Missouri with at least one (1) year of experience with the direct care to the elderly, disabled or infirm; or

4. Have at least three (3) years experience with the direct care to the elderly disabled or infirm;

(C) All in-home service workers employed by the provider shall meet the following requirements:

1. Be at least eighteen (18) years of age;

2. Be able to read, write and follow directions; and meet at least one (1) of the following requirements:

A. Have at least six (6) months paid work experience as an agency homemaker, nurse aide, maid or household worker; or

B. At least one (1) years experience, paid or unpaid, in caring for children or for sick or aged individuals; or

C. Successful completion of formal training in nursing arts or as a nurse aide or home health aide;

(D) All advance personal care aides and advanced respite care workers employed by the provider shall be—

1. A licensed practical nurse; or

2. Certified nurse assistant; or

3. A competency evaluated home health aide having completed both written and demonstration portions of the test required by
the Missouri Department of Health and Senior Services and 42 CFR 484.36; or

4. Documented to have worked successfully for the provider for a minimum of three (3) consecutive months while working at least fifteen (15) hours per week as an in-home aide that has received personal care training;

(E) All individuals employed to deliver authorized nurse visits shall be currently licensed to practice as a registered nurse or a licensed practical nurse in Missouri;

(F) The division does not require employees delivering only chore services outside the client’s home as specified in (8)(J) to have experience as required in (19)(C)(2) of this rule; and

(G) The provider shall ensure that all employees are registered with the Family Care Safety Registry (FCSR) pursuant to the requirements of sections 210.900, RSMO to 210.936, RSMO and 660.317.7, RSMO, Supp. 2005.

(20) The RN required by (19)(A) of this rule will be primarily responsible for ensuring that policies and procedures of the in-home service provider meet the clinical standards for professional care of clients, training of staff, and general clinical integrity of the in-home service provider. Such responsibilities shall include, at a minimum, the following functions:

(A) Monitor or provide oversight to staff that supervise in-home workers in the direct provision of services to assure that services are being delivered in accordance with the care plan;

(B) Direct or oversee staff responsible for in-home worker orientation and in-service training required herein; assure all training requirements are met; and ensure that in-home workers are trained to competently perform all basic and advanced service tasks as specified in this rule;

(C) Provide oversight to the process and documents used by the staff who conduct annual supervisory visits and have in place a system that ensures that completed evaluations are reviewed by the nurse when appropriate;

(D) Assure that appropriate recommendations or reports are forwarded to the division including: requests to increase, reduce or discontinue services, changes in the client’s condition, noncompliance with care plan, nondelivery of authorized services, or the need for increased division involvement;

(E) Establish, implement and enforce a policy governing communicable diseases that prohibits provider staff contact with clients when the employee has a communicable condition including colds or flu;

(F) Assure compliance with reporting requirements governing communicable diseases, including hepatitis and tuberculosis, as set by the Missouri Department of Health and Senior Services (19 CSR 20-20.020); and

(G) Monitor or provide oversight of nurse tasks or functions delegated to and performed by the LPN.

(21) The in-home service supervisor’s responsibilities shall include, at a minimum, the following functions:

(A) Monitoring the provision of services by the in-home service worker to assure that services are being delivered in accordance with the care plan. This shall be primarily in the form of at least a monthly review and comparison of the worker’s record of provided services with the care plan.

(B) Documentation must be kept on clients with a delivery rate of less than eighty percent (80%) of the authorized units of in-home service. For each client with a delivery rate less than eighty percent (80%) of the authorized units of in-home services authorized for the time period being reviewed, the number of units of service delivered and the non-delivery code will be sent to the division regional manager monthly on a form acceptable to the regional manager. Discrepancies for these clients concerning the frequency of delivered services and/or the in-home service tasks delivered, and the corrective action taken, will be signed and dated by the supervisor and be readily available for monitoring or inspection;

(C) Evaluating, in writing, each in-home service aide’s performance at least annually. The evaluation shall be based in part on at least one (1) on-site visit. The aide must be present during the visit. The evaluation will include, in addition to the aide’s performance, the adequacy of the care plan, including review of the care plan with the client. The written report of the evaluation shall contain documentation of the visit, including the client’s name, the date and time of the visit, the aide’s name and the supervisor’s observations and notes from the visit. The evaluation shall be signed and dated by the supervisor who prepared it and by the aide. If the required evaluation is not performed or not documented, the aide’s qualifications to provide the services may be presumed inadequate and all payments made for services by that aide may be recouped;

(D) Communicating with the division case manager and provider RN regarding changes in any client’s condition, changes in scope or frequency of service delivery and recommending changes in the number of units of service per month including written documentation of that communication; and

(E) Assure that all individuals, who may not be considered employees, but work for the provider in any capacity involving direct care of clients have a signed agreement detailing the employment arrangement, including all rights and responsibilities. Such agreement would apply to all individuals hired through contract or other employment arrangement.

(22) The in-home service provider shall have a written plan for providing training for new aides, respite care workers and homemakers which shall include, at a minimum, the following requirements:

(A) Twenty (20) hours of orientation training for in-home service workers, including at least two (2) hours orientation to the provider agency and the agency’s protocols for handling emergencies, within thirty (30) days of employment.

1. Eight (8) hours of classroom training will be provided prior to the first day of client contact.

2. New employee orientation curricula shall include an overview of Alzheimer’s disease and related dementias and methods of communicating with persons with dementia pursuant to the requirements of section 660.050.8, RSMO.

3. Twelve (12) hours of required orientation training may be waived for aides and homemakers with adequate documentation in the employee’s records that s/he has received similar training during the current or preceding year or has been employed at least half-time for six (6) months or more within the current or preceding year.

4. All orientation training (except the required two (2) hours provider agency orientation) may be waived with documentation, placed in the aide’s personnel record, that the aide is a licensed practical nurse, registered nurse or certified nurse assistant. The documentation shall include the employee’s license or certification number which must be current and in good standing at the time the training was waived;

(B) Ten (10) hours of in-service training annually are required after the first twelve (12) months of employment. In-service training curricula shall include updates on Alzheimer’s disease and related dementia; and

(C) Additional training requirements for in-home workers providing advanced respite must be determined and provided by a provider agency following assessment of the client’s condition and needs.
23. The in-home service provider shall have written documentation of all basic and in-service training provided which includes, at a minimum:

(A) A report of each employee's training in that employee's personnel record. The report shall document the dates of all classroom or on-the-job training, the trainer's name, topics, number of hours and location, the date of the first client contact and shall include the aide's signature.

(B) If a provider waives the in-service training, the employee's training record shall contain documentation sufficient to support the waiver. In-service training shall not be waived, unless the employee's record contains documentation that the employee has received Alzheimer's disease and related dementias training.

(C) The provider agency shall keep a training record or folder that contains:

1. A list of all training sessions held by the provider to fulfill training requirements;
2. A copy of all agendas showing date, time and duration of training sessions; and
3. Qualifications of trainer(s), if other than the provider agency RN.

24. The in-home service provider shall maintain, at a minimum, the following records in a central location for five (5) years. Records must be provided to the department staff or designees upon request, and must be maintained in a manner that will ensure they are readily available for monitoring or inspection. Records include:

(A) Individual client case or clinical records including records of service provision. These are confidential and shall be protected from damage, theft and unauthorized inspection and shall include, at a minimum, the following:

1. The authorization for services forms from the division which documents authorization for all units of service provided;
2. Individual worker delivery records that accurately document the client's name, dates of service delivery, beginning time and ending time for each service delivery date, activities or tasks performed, aide's signature and the client's signature verifying each date(s) of service. If the client is unable to sign, another responsible person present in the home during service delivery may sign to verify the time and activities reported or the client may make his/her mark (s) which shall be witnessed by a minimum of one (1) person who may be the aide or homemaker. If these documents are not filed in the client's case record, they must be readily available for monitoring or inspection;
3. Documentation explaining discrepancies between authorized and delivered services including a description of corrective action taken, when applicable, and documentation of information forwarded to the division;
4. All registered nurse clinical notes concerning the client;
5. Documentation of all correspondence and contacts with the client's physician or other care providers;
6. Copies of written communication transmitted to and from the division case manager; and
7. Any other pertinent documentation regarding the client.

(B) Individual personnel record for each employee which is a confidential record and shall be protected from damage, theft and unauthorized inspection and shall include, at a minimum, the following:

1. Employment application containing the employee's signature and document sufficient to verify the employee meets age, education, and work experience requirements. The record shall document employment and termination dates;
2. Documentation of at least two (2) credible reference contacts;
3. Documentation concerning all training and certification received;
4. Documentation supporting any waiver of employment or training requirements;
5. Annual performance evaluation which includes observations from one (1) on-site visit;
6. A signed statement documenting that the employee received and reviewed a copy of the client's rights, the code of ethics and the service provider's policy regarding confidentiality of client information and that all were explained prior to service delivery;
7. A signed statement verifying that the supervisor received and reviewed a copy of the in-home service standards;
8. Statement identifying the employee's position, including whether the employee performs administrative duties for the provider or delivers services to clients;
9. Returned permanent ID for a terminated employee or documentation of why it is not available; and
10. Verification of the current Missouri certified nurse assistant, licensed practical nurse or registered nurse license including, at least, the license or certificate number.

25. The provider agency shall maintain, at a minimum, the following records:

(A) Documentation explaining discrepancies between authorized and delivered services including a description of corrective action taken, when applicable, and documentation of information forwarded to the division;

(B) Documentation of all correspondence and contacts with the client's physician or other care providers;

(C) The provider agency shall keep a training record or folder that contains:

1. A list of all training sessions held by the provider to fulfill training requirements;
2. A copy of all agendas showing date, time and duration of training sessions; and
3. Qualifications of trainer(s), if other than the provider agency RN.


19 CSR 15-7.040 Transportation Service Standards

PURPOSE: This rule sets forth the minimum standards to be met by a transportation service provider receiving state or federal funds for the operation of transportation services for persons aged sixty and over and handicapped adults aged eighteen through fifty-nine and applies to all transportation service delivery systems, both direct and indirect.

1. The transportation service provider shall meet the following requirements:

(A) Have sufficient phones and personnel to handle calls regarding the service;

(B) Develop and operate an efficient system for scheduling trips to assure that the service is dependable and no passenger is left stranded;

(C) Service will be provided for the duration of a contract period or as agreed upon by the AAA and service provider; and

(D) Have a program manual available to all employees and volunteers detailing its operational policies, procedures and general requirements applicable to service provision.
Chapter 7—Service Standards

2 (a) A driver is any individual engaged in the operation of a motor vehicle providing transportation services to persons over age 60 and/or disabled between the ages of 18 and 59; and whose sponsoring agency and/or employer is a recipient of funding through the Division of Aging and/or an area agency on aging. Documentation shall be maintained by the service provider, on each driver, that includes:

(A) The driver’s health record. Documentation, signed by the driver, that no physical or health limitation exists that prevents competent operation of the motor vehicle or ability to assist any service recipient in and out of the vehicle who requires or requests it;

(B) Either a current and valid common carrier or livery permit issued by regulatory entities such as the Missouri Department of Economic Development, Division of Transportation, or local municipal taxi/livery ordinances attesting to the driver’s qualifications to transport persons. Or, in lieu of a license or permit issued by a cognizant regulatory body, the driver’s driving record showing that the driver has had no driving while intoxicated or under the influence of a controlled substance conviction within three (3) years prior to driving for the transportation service provider and that the driver has not had driver/chaffer’s license revoked within three (3) years prior to driving for the provider;

(C) A copy of the driver’s valid and current chauffeur’s license and/or driver’s license; and

(D) Documentation of the driver’s participation in orientation and in-service training.

(3) Orientation and In-Service Training.

(A) Prior to actual transport of service recipients, each driver shall have completed the transportation service provider orientation training. Any volunteer who even occasionally transports shall have received at least a brief orientation.

(B) Orientation shall include the following:

1. Transportation service provider policies and procedures;
2. Characteristics of the aging process and major disabling conditions;
3. Use of common assistive devices by elderly and handicapped persons;
4. Methods of handling wheelchairs;
5. Methods of moving, lifting, and transferring passengers with mobility limitations or who use assistive devices;
6. Operation of lifts, ramps and wheelchair securement devices if the vehicle to be operated is equipped with them;
7. Use of a fire extinguisher;
8. Methods of keeping accurate and accountable records or reports, or both;

9. Written instructions on proper actions to be taken in problem situations (for example, emergency situations, passenger problems and vehicle breakdowns); and

10. Successful completion of an in-service training course in first aid or emergency care that included at least:

   A. Basic first aid;
   B. Cardiopulmonary resuscitation;
   C. Heimlich maneuver;
   D. Guidelines on when to attempt first aid or when to take alternative action; and
   E. Instruction on universal precautions regarding handling body fluids, including how to use a blood-borne pathogen kit.

(C) The transportation service provider should require drivers to participate in a defensive driving training program.

(D) Other personnel, such as schedulers and dispatchers, should receive training appropriate to their job functions.

(4) Fiscal and Program Records.

(A) Fiscal and program records shall be submitted to the contracting agency on a timely and proper basis.

(B) The service provider shall maintain time records that document the number of hours worked per week for each employee and volunteer.

(C) Documentation verifying the recipient’s use of the service provider’s transportation system shall be maintained.

(D) The transportation service provider shall have a method, approved by the contracting agency, for documenting units of service delivered and obtaining an unduplicated count of individual service recipients.

(5) Files and records regarding vehicles and/or vehicular fleets shall be kept by the provider that should contain the following documentation:

(A) Vehicle ownership or lease agreement;

(B) Current vehicle license;

(C) Current vehicle safety inspection as required by state law;

(D) Vehicle maintenance schedule including the date of each service, repair and replacement; and

(E) That transportation service provider-owned or leased vehicle is properly insured.

(F) Any driver, using personally-owned vehicles to transport service recipients shall maintain proper vehicle insurance and shall sign an agreement indicating understanding and acceptance of liability.

(G) Vehicles shall meet the following requirements:

(A) All vehicles shall be legally licensed;

(B) All vehicles shall receive a vehicle safety inspection, as required by state law, shall be clean and in good repair;

(C) All vehicles shall carry the following safety equipment:

    1. Extra electrical fuses;
    2. Fire extinguisher, ABC type;
    3. Three (3) reflective orange triangles or similar emergency warning devices;
    4. Spare tire and jack unless they are radio/phone equipped and able to summon assistance;
    5. Flashlight;
    6. Ice scraper;
    7. Emergency first-aid kit; and
    8. Blood-borne pathogen kit;

(D) All vehicles shall have for each passenger an available seat that is securely fastened to the floor of the vehicle. Cars and vans shall have a usable seat belt, include seat belt extenders as needed, for each person being transported;

(E) All vans and buses shall have accessible emergency exit(s) with appropriate emergency procedures posted in compliance with Federal Motor Vehicle Safety Standard No. 217; and

(F) All vans and buses shall have a stationary or removable step to aid entry and exit of the vehicle. This step shall be capable of safely supporting three hundred pounds (300 lbs.); shall be placed that it is no more than twelve inches (12") above ground level; and shall have a nonskid top surface no less than eight inches by twelve inches (8"x12"). Removable steps shall be properly secured while the vehicle is in motion.

(8) Vehicle requirements transporting an individual remaining in a wheelchair are as follows:

(A) Wheelchair safety locks shall be available and used when a wheelchair is in use during transport if a vehicle is ramp/lift equipped;

(B) All wheelchair lifts used on vehicles shall be certified as being capable of regularly servicing a minimum capacity of six hundred pounds (600 lbs.); and

(C) All wheelchair ramps used on vehicles shall be certified as being capable of regularly servicing a minimum capacity of four hundred pounds (400 lbs.).

(9) Drivers shall observe the following safety precautions:

(A) Assure that all passengers are seated before vehicle is put into motion;

(B) Encourage passengers to use seat belts;

(C) Not allow firearms, alcoholic beverages in opened containers, unauthorized con-
Rules of
Department of Health and
Senior Services
Division 15—Division of Senior and Disability Services
Chapter 9—Electronic Visit Verification

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 CSR 15-9.100 Definitions</td>
<td></td>
</tr>
<tr>
<td>19 CSR 15-9.200 Electronic Visit Verification</td>
<td></td>
</tr>
</tbody>
</table>

3
Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 15—Division of Senior and Disability Services
Chapter 9—Electronic Visit Verification

19 CSR 15-9.100 Definitions

PURPOSE: This rule defines terms used in establishing procedures for the Electronic Visit Verification requirements for in-home service providers and consumer-directed services vendors. These definitions apply solely to the information in this chapter.

(1) Electronic Visit Verification (EVV). A telephone and computer-based system or other electronic technology used for the purpose of verifying and reporting the delivery of in-home services from the participant’s home and consumer directed services from the participant’s home if the services are being provided there or another location where the service is being provided as authorized by the Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS).

(2) Participant. An individual receiving Home and Community Based Services (HCBS), either a consumer through consumer-directed services, as defined in 19 CSR 15-8.100, or a service recipient, as defined in 19 CSR 15-7.005, in the in-home services program.

(3) Attendant. The individual providing the Home and Community Based Services to the participant.

(4) Service.
(A) Personal Care and Advanced Personal Care, as defined in 13 CSR 70-91.010.
(B) Consumer Directed Services, as defined in 19 CSR 15-8.100.
(C) Chore, Homemaker, Basic In-home Respite, Advanced Respite, Basic Block Respite, Advanced Block Respite, and Advanced Respite Daily as defined in 19 CSR 15-7.021.

(5) Task. Tasks for all HCBS service types, including, but not limited to, tasks defined in 13 CSR 70-91, 19 CSR 15-7, and 19 CSR 15-8.


19 CSR 15-9.200 Electronic Visit Verification

PURPOSE: This rule establishes the minimum necessary criteria of the telephone tracking system required of in-home services providers and consumer-directed services vendors in sections 660.023 and 208.909, RSMo, respectively.

(1) The Electronic Visit Verification (EVV) system must utilize one (1) or more of the following:
(A) The participant’s personal landline or personal cellular phone;
(B) Location technologies including Near Field Communication (NFC), Global Positioning System (GPS), and Bluetooth Low Energy (BLE);
(C) An affixed electronic device at the participant’s location;
(D) A biometric verification system which utilizes voice pattern identifications; or
(E) An alternative technology which meets the requirements in section (2) of this rule.

(2) At a minimum, the EVV system must meet the following requirements:
(A) Document and verify the participant’s identity, either by the participant’s personal telephone, a unique number assigned to the participant, or through alternative technology;
(B) Document and verify the attendant by the assignment of a personal identification number unique to the attendant or through alternative technology;
(C) Document the exact date of services delivered;
(D) Document the exact time the services begin;
(E) Document the exact time the services end;
(F) Support changes in the care plan which are approved by the Department of Health and Senior Services;
(G) Allow for the addition of services approved by the Department of Health and Senior Services;
(H) Be capable of retrieving current and archived data to produce reports of services delivered, tasks performed, participant identity, beginning and ending times of service, and date of services in summary fashion that constitute adequate documentation of services delivered. Any report shall include an explanation of codes utilized by the provider/vendor (e.g., 10—Personal Care) and include the vendor/provider’s identity by either name of vendor/provider and/or National Provider Identifier (NPI); and

(1) Maintain reliable backup and recovery processes that ensure that all data is preserved in the event of a system malfunction or disaster situation.

(3) Providers/Vendors, shall, either through EVV or other documentation—
(A) Accommodate more than one (1) participant and/or attendant in the same home or at the same phone number;
(B) Document the services and tasks delivered to each participant;
(C) Document the justification of manual modifications, adjustments, or exceptions after the attendant has entered or failed to enter the information as required in subsections (2)(A)-(E) of this rule; and
(D) Retain all data regarding the delivery of services for a minimum of six (6) years.

(4) In instances where a telephone or other electronic verification options, as stated in section (1) of this rule, are not available or accessible in the participant’s home, or the participant refuses to allow the use of EVV, the vendor/provider must have documentation on file explaining the reason the attendant is not using EVV. When not utilizing an EVV system, the vendor/provider shall file a claim for services rendered as specified in 13 CSR 70-3.030.

(5) In no way shall this rule prohibit the vendor/provider’s ability to accrue partial units pursuant to 13 CSR 70-91.

(6) Reports from the EVV systems are subject to review and audit by the Departments of Social Services and Health and Senior Services or their designee.

(7) Vendors’/providers’ EVV systems shall be capable of producing reimbursement requests for participant approval that ensure accuracy and compliance with program expectations for both the participant and vendor/provider.


# Rules of
## Department of Health and Senior Services
### Division 30—Division of Regulation and Licensure
#### Chapter 82—General Licensure Requirements

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 CSR 30-82.010 General Licensure Requirements</td>
<td>3</td>
</tr>
<tr>
<td>19 CSR 30-82.015 Long-Term Care Receiverships</td>
<td>7</td>
</tr>
<tr>
<td>19 CSR 30-82.020 Classification of Rules</td>
<td>8</td>
</tr>
<tr>
<td>19 CSR 30-82.030 Assessment of Availability of Beds</td>
<td>9</td>
</tr>
<tr>
<td>19 CSR 30-82.050 Transfer and Discharge Procedures</td>
<td>10</td>
</tr>
<tr>
<td>19 CSR 30-82.060 Hiring Restrictions—Good Cause Waiver</td>
<td>12</td>
</tr>
<tr>
<td>19 CSR 30-82.070 Alzheimer’s Demonstration Projects (Rescinded September 30, 2013)</td>
<td>14</td>
</tr>
<tr>
<td>19 CSR 30-82.080 Nursing Facility Quality of Care Improvement Program</td>
<td>15</td>
</tr>
</tbody>
</table>
member of the resident's family received notice of the discharge, a copy of the hearing decision shall be mailed to the family member upon request.

(11) The burden of showing that the facility has complied with all requirements for appropriate discharge of the resident shall be upon the facility. The resident may provide any additional evidence competent to show that the facility has not met its burden.

(12) The resident may obtain legal counsel, represent him/herself or use a relative, a friend or other spokesperson. All natural parties, including residents, sole proprietors of a facility and a partner of a facility operated in the partnership form of business, may represent themselves in a pro se capacity on behalf of the facility. Corporate operators of a facility may only be represented by an attorney licensed to practice law in Missouri.

(13) Hearings shall be subject to the hearing procedures found in 42 CFR Chapter IV, Part 483, subpart E and the Missouri Administrative Procedures Act, specifically sections 536.070 through 536.080, RSMo, which include, but are not limited to, oral and written evidence, witnesses, objections, official notices, affidavits, transcripts, depositions and other discovery methods, sanctions, oral arguments and written briefs. Written medical statements by a physician, psychiatrist or psychologist shall be admitted as relevant and probative evidence and shall be given due weight in consideration by the director or his/her designated hearing official. An audio-tape recording of the hearing shall be made unless it is agreed by both parties to substitute a certified transcript.

(14) If the decision is that there is no cause for discharge, the resident shall be permitted to remain in the facility. If the decision is in the facility's favor, the resident shall be granted an additional ten (10) days after the decision is received for purpose of relocation, and the facility shall assist the resident in making suitable arrangements for relocation. If the resident prevails and has already been discharged, the facility shall notify the resident, the qualified representative, or any other responsible party who will assure that the resident is made aware of the decision and that the resident may return to the facility. In the event that there are no beds available, the facility shall admit the resident to occupy the first available bed without regard to any waiting list maintained by the facility.

19 CSR 30-82.060 Hiring Restrictions—Good Cause Waiver

PURPOSE: This rule is being promulgated to establish the procedure by which persons with criminal convictions may seek a waiver allowing them to be employed by health care and mental health providers despite the hiring restrictions found in section 660.317, RSMo. The waivers are to be for "good cause" as defined by that statute. This rule sets forth both the procedure for seeking waivers and the facts and circumstances to be considered by the Department of Social Services in determining "good cause."

(1) Definitions.

(A) Applicant means a person who has been or would be rejected for employment by a provider due to the hiring restrictions found in section 660.317, RSMo.

(B) Department means the Department of Health and Senior Services.

(C) Determination means the decision issued by the director of the Department of Health and Senior Services or the director's designee based on the factual, procedural or causal issues of the request for waiver.

(D) Director means the director of the Department of Health and Senior Services.

(E) Good Cause Waiver means a finding that it is reasonable to believe that the restrictions imposed by section 660.317, RSMo, on the employment of an applicant may be waived after an examination of the applicant's prior work history and other relevant factors is conducted and demonstrates that such applicant does not present a risk to the health or safety of residents, patients or clients if employed by a provider.

(F) Provider means any person, corporation or association who—

1. Is licensed as an operator pursuant to Chapter 198, RSMo;

2. Provides in-home services under contract with the Department of Health and Senior Services;

3. Employs nurses or nursing assistants for temporary or intermittent placement in health care facilities;

4. Is an entity licensed pursuant to Chapter 197, RSMo;

5. Is a public or private facility, day program, residential facility or specialized service operated, funded or licensed by the Department of Mental Health; or

6. Is a licensed adult day care provider.

(G) Reference means a written statement of character, qualification or ability issued on behalf of the applicant by a person who is not related to or residing with the applicant requesting a good cause waiver.

(H) Sponsor means the current or potential employer of the applicant, or a training program, agency or school in which the applicant is or was a student enrolled for the purpose of earning a professional license, certification or otherwise becoming qualified to perform the duties of an occupation.

(2) Any person who is not eligible for employment by a provider due to the hiring restrictions found in section 660.317, RSMo, may apply to the director for a good cause waiver. If the director, or the director's designee, determines that the applicant has demonstrated good cause, such restrictions prohibiting such persons from being hired by a provider shall be waived and such persons may be so employed unless rejected for employment on other grounds. Hiring restrictions based on the Department of Health and Senior Services' employee disqualification list established pursuant to section 660.315, RSMo, are not subject to a waiver.

(3) The director, or the director's designee, shall accept an application for a good cause waiver only if the application—

(A) Is submitted in writing by the applicant on the form provided by the department;

(B) Is legible;

(C) Is signed by the applicant;

(D) Includes an indication of the type of waiver that is being requested;

(E) Includes a complete history of residency since the earliest disqualifying offense or incident;

(F) Includes a complete employment history since the age of eighteen (18) years;

(G) Includes an attached explanation written by the applicant as to why the applicant believes he or she no longer poses a risk to the health, safety or welfare of residents, patients or clients;

(H) Includes an attached description written by the applicant of the events that resulted in each disqualifying offense or incident;

(I) Includes attached documentation on the applicant's professional, vocational or occupational licensure, certification or registration
history and current status, if any, in this state and any other state;

(J) Includes at least one (1) reference letter from a sponsor. If the applicant is not able to obtain a sponsor, the applicant shall so state, shall identify those potential sponsors who have been approached by the applicant, and shall submit three (3) reference letters from individuals knowledgeable of the applicant’s character or work history who are not related to or residing with the applicant;

(K) Includes a criminal history record from the Missouri State Highway Patrol if requesting a waiver of disqualifying criminal offenses;

(L) Includes a certified court document for each disqualifying criminal offense. If such document is not obtainable, a written and signed statement from the court indicating that no such record exists must be submitted;

(M) Includes certified investigative reports from the Department of Social Services if requesting a waiver of child abuse or neglect findings or a waiver of foster parent license denial, revocation, or involuntary suspension;

(N) Includes certified investigative reports or other documentation of the incident(s) which resulted in the applicant’s inclusion on all other lists in the Family Care Safety Registry for which waiver is requested; and

(O) If in addition to the criminal offense(s) for which the applicant is requesting a waiver the applicant has any pending felony or misdemeanor charges, includes a statement explaining the circumstances and certified copies of the charging documents for all pending criminal charges; and, in the case of an applicant seeking a position with an in-home services provider agency or home health agency, if in addition to the circumstances related to the listing on any of the background checklists of the Family Care Safety Registry for which waiver is requested, includes a statement explaining the circumstances and certified copies of documents relating to those circumstances.

(4) The director, or the director’s designee, will not consider any application for a good cause waiver unless it is fully completed, signed by the applicant, and contains all required attachments.

(5) Each completed application will be reviewed by a good cause waiver committee of two (2) or more employees of the depart-

ment. The director shall determine the size of the committee and shall, from time to time, appoint members to serve on the committee.

(A) If the applicant seeks a good cause waiver of placement on the disqualification list maintained by the Department of Mental Health, the director shall appoint an employee of the Department of Mental Health recommended by the director of the Department of Mental Health to serve on the good cause waiver committee.

(B) A member of the good cause waiver committee shall recuse himself or herself in a good cause waiver review in which the member’s impartiality might reasonably be questioned, including but not limited to instances where the committee member has a personal bias or prejudice concerning the applicant, or personal knowledge of evidentiary facts concerning the application for good cause waiver.

(6) The department may, at any time during the application process or review thereof, request additional information from the applicant. If the applicant fails to supply any requested additional information within thirty (30) calendar days of the date of the request, unless the applicant requests and the department grants an extension, the department will consider the application for good cause waiver to be withdrawn by the applicant.

(7) The department may request the applicant, prior to the completion of the review, to appear in person to answer questions about his or her application. If the applicant is requested to appear in person, the department, in its sole discretion, shall determine the location for the appearance and may conduct any such proceedings using electronic means, including but not limited to telephon-

ic or video conferencing. The department shall review and may investigate the information contained in each application for completeness, accuracy and truthfulness. The burden of proof shall be upon the applicant to demonstrate that he or she no longer poses a risk to the health, safety or welfare of resi-

dents, patients or clients. The following factors shall be considered in determining whether a good cause waiver should be granted:

(A) The applicant’s age at the time the crime was committed or at the time the incident occurred that resulted in the applicant being listed on the background checklists in the Family Care Safety Registry;

(B) The circumstances surrounding the crime or surrounding the incident that resulted in the applicant being listed on the back-
ground checklists in the Family Care Safety Registry;

(C) The length of time since the conviction or since the occurrence of the incident that resulted in the applicant being listed on the background checklists in the Family Care Safety Registry;

(D) The length of time since the applicant completed his or her sentence for the disqualifying conviction(s), whether or not the applicant was confined, conditionally released, on parole or probation;

(E) The applicant’s entire criminal history and entire history of all incidents that resulted in the applicant being listed on the back-
ground checklists in the Family Care Safety Registry, including whether that history shows a repetitive pattern of offenses or inci-
dents;

(F) The applicant’s prior work history;

(G) Whether the applicant had been employed in good standing by a provider but subsequently became ineligible for employ-
ment due to the hiring restrictions in section 660.317, RSMo;

(H) Whether the applicant has been convicted or found guilty of, or plead guilty or nolo contendere to any offense displaying extreme brutality or disregard for human wel-
fare or safety;

(I) Whether the applicant has omitted a material fact or misrepresented a material fact pertaining to his or her criminal or employment history or to his or her history of incidents that resulted in his or her being listed on the background checklists in the Family Care Safety Registry;

(J) Whether the applicant has ever been listed on the Employee Disqualification List maintained by the department as provided in section 660.315, RSMo;

(K) Whether the applicant’s criminal offenses were committed, or the incidents that resulted in the applicant being listed on the background checklists in the Family Care Safety Registry occurred, during the time he or she was acting as a provider or as an employee for a provider;

(L) Whether the applicant has, while disquali-

fied from employment by a provider, obtained employment by fraud, deceit, deception or misrepresentation, including misrep-

resentation of his or her identity;

(M) Whether the applicant has ever had a professional or occupational license, certification, or registration revoked, suspended, or otherwise disciplined;

(N) Any other information relevant to the applicant’s employment background or past actions indicating whether he or she would pose a risk to the health, safety or welfare of residents, patients or clients; and
(O) Whether the applicant has supplied all information requested by the department.

(8) If, at the time of an application for a waiver, or during the waiver consideration process, the applicant has been charged or indicted for, but not convicted of, any of the crimes covered under the provisions of section 660.317, RSMo, the division will hold the request for waiver in abeyance while such charges are pending or until a court of competent jurisdiction enters a judgment or order disposing of the matter.

(9) Each applicant who submits a waiver application meeting the requirements of section 3 of this rule shall be notified in writing by the director, or the director’s designee, as to whether his or her application has resulted in a determination of good cause or no good cause. Such notification shall be effective if sent to the applicant’s address given on the application.

(10) Any good cause waiver granted to an applicant applies only to:

(A) The specific disqualifying conviction(s), finding(s) of guilt, plea(s) of guilty or nolo contendere, as contained in the certifying copies of the court documents which are required in the application; and/or

(B) The incident(s) that resulted in the applicant being listed on the background checklists in the Family Care Safety Registry, as contained in the investigative reports or other supporting documentation required in the application or subsequently requested by the department.

(11) Any good cause waiver granted to an applicant applies only to those disqualifying criminal convictions on incidents that result in the applicant being listed on the background checklists in the Family Care Safety Registry, as contained under the provisions of section 660.317, RSMo, and shall not apply to any other hiring restriction or exclusion imposed by any other federal or state laws or regulations.

(12) The director, or the director’s designee, may withdraw a good cause waiver if it receives information or finds that—

(A) The applicant has omitted a material fact or misrepresented a material fact in seeking a good cause waiver;

(B) The applicant has been subsequently convicted or found guilty of, or pled guilty or nolo contendere to any class A or B felony violation of Chapter 565, 566, or 569, RSMo, or any violation of subsection 3 of section 198.070, RSMo, or section 568.020, RSMo, in this state or any other state;

(C) Such applicant is a prospective or current employee of an in-home services provider or home health agency and has been subsequently involved in an incident that results in the applicant being listed on any of the background checklists in the Family Care Safety Registry;

(D) The applicant has omitted, misrepresented or failed to disclose or provide any of the information required by section 660.317, RSMo, or the provisions of this rule; or

(E) There has been a material change in the circumstances upon which the good cause waiver was granted.

(13) If the good cause waiver is withdrawn by the department, the notice of such withdrawal shall be mailed by the department to the applicant’s last known address, with a copy of the notice sent to the applicant’s last known employer, if any.

(14) No applicant may be employed in a direct care or direct service position with a provider during the pendency of a request for waiver unless the applicant has been continuously employed by that provider prior to August 28, 2003. If an applicant is employed on or after August 28, 2003, he or she may be employed following submission of a completed waiver application on a conditional basis to provide in-home services or home health services to any in-home services client or home health patient during the pendency of that waiver application if:

(A) The disqualifying crime is not one that would preclude employment pursuant to subsection 6 of section 660.317, RSMo; and

(B) The applicant is not listed on the Department of Health and Senior Services’ employee disqualification list established pursuant to section 660.315, RSMo.

(15) If a waiver is denied to an applicant employed on or after August 28, 2003, on a conditional basis, the conditional employment shall immediately terminate.

(16) Applicants who have been denied a good cause waiver, or who have had their good cause waivers withdrawn by the department, may reapply one (1) time every twelve (12) months, or whenever the circumstances related to the disqualifying conviction(s) have changed.

(17) Each provider shall be responsible for—

(A) Requesting criminal background checks on all prospective employees, regardless of waiver status, in accordance with the provisions of sections 660.317 and 43.540, RSMo; and

(B) Contacting the department to confirm the validity of a prospective employee’s good cause waiver prior to hiring the prospective employee if the prospective employee reveals the existence of a good cause waiver or reveals the existence of an otherwise disqualifying circumstance.

(18) Each in-home services provider or home health provider shall also be responsible for—

(A) Requesting Family Care Safety Registry background screenings on all prospective employees, regardless of waiver status, in accordance with the provisions of section 660.317.7, RSMo; and

(B) Contacting the department to confirm the validity of a prospective employee’s good cause waiver prior to hiring the prospective employee if the prospective employee reveals the existence of a good cause waiver or reveals the existence of an otherwise disqualifying circumstance.

(19) All applications for good cause waivers and related documents shall become permanent records maintained by the department.


19 CSR 30-82.070 Alzheimer’s Demonstration Projects

(Rescinded September 30, 2013)

• Problems common to the elderly and disabled;
• Recognizing and reporting abuse or neglect;
• AIDS education;
• Alzheimer’s and related dementia; and
• Death and dying.

13.7 RECORDS

The personal care provider shall document implementation of requirements for the following, as applicable:

• Coordination with other providers;
• Non-discrimination on basis of disabilities; and
• Administrative policies and procedures.

13.7.A PARTICIPANT CASE RECORD

The provider shall maintain a participant case record including records of service provision for each participant. The participant record is confidential and shall be protected from damage, theft, and unauthorized inspection. It shall be maintained in a central location, and shall contain at least the following:

• The Authorization for Services form and the Service Authorization Supplement Form, which documents authorization for all units of service provided;
• The participant’s service log sheets, which must contain the personal care aide’s name, the participant’s name, dates of service delivery, time spent and activities performed on each date, and the participant’s signature for each date of service. If the participant cannot write, his or her mark (X) shall be witnessed by at least one person who may be the personal care aide. Another responsible person, present in the home while the service is delivered, may sign the service log for each date of service.
• Each provider may design its own service log sheet, but all paid units of service must be documented. If these documents are not maintained in the participant’s case record, they must be maintained in an area that is readily available for monitoring or inspection by the Departments of Social Services and Health and Senior Services;
• Documentation of undelivered services;
• Residential Care Facilities (RCF) and Assisted Living Facilities (ALF) must maintain documentation which must contain the personal care aide’s name, the participant’s name, dates of service delivery, and activities performed on each
date, and the participant’s signature for each date of service. All paid units of service must be documented. Reference section 13.7.D(1) of this manual and 13 CSR 70-91.010(4)(A)2.A-F for additional documentation requirements. If these documents are not maintained in the participant’s case record, they must be maintained in an area that is readily available for monitoring or inspection by the Departments of Social Services and Health and Senior Services.

- The RN’s written notes concerning any on-site visits made to the participant. Refer to Section 13.5.A

- Documentation of all correspondence and contacts with the participant’s physician or other care providers;

- Any other pertinent documentation regarding the participant. Refer to Sections 13.8.D and 13.9.G(2); and

- Documentation that prior to initiation of service the participant was informed of their rights under the Advanced Health Care Directive. Documentation should include whether an Advanced Health Care Directive was executed by the participant. For more information concerning Advanced Health Care Directive, please reference Section 21.

13.7.B PERSONNEL RECORD

The provider must maintain an individual record for each personal care aide. A personnel record is a confidential record and shall be protected from damage, theft and/or unauthorized inspection. An individual personnel record shall include, at a minimum, the following:

- Employment application with the personal care aide’s signature showing, education and work experience.

- The aide’s date of birth, date of employment and the date the provider terminated the aide (if applicable) must be documented in the personnel file by the provider;

- For supervisory staff, documentation that they have been provided with and have read Section 13.3.A of this provider manual;

- Documentation of at least 2 references contacted;

- Documentation of basic and in-service training received (individual training report; reference Section 13.6.A);

- Documentation of any waiver or reduction of employment or training requirements (reference Section 13.6.C);

- Annual performance evaluation which includes observations from at least one on-site visit (reference Section 13.4);

PRODUCTION: 11/21/2018
• Signed statement(s) verifying that the personal care aide received a copy of the participant’s rights and the code of ethics, and that the provider’s policy regarding confidentiality of participant information was explained prior to service delivery;

• Statement identifying the personal care aide’s position, including whether the employee performs administrative duties for the provider or delivers services to participants; and

• Returned I.D. card for a terminated personal care aide, or documentation of why it is not available.

The provider must also maintain the written plans for basic and in-service training (Section 13.6), and the supervisor’s and the RN’s on-site visiting log (Section 13.4.A).

13.7.C RETENTION OF RECORDS

MO HealthNet providers must retain for 5 years, from the date of service, fiscal and medical records that coincide with and fully document services billed to the MO HealthNet Agency, and must furnish or make the records available for inspection or audit by the Departments of Social Services and Health and Senior Services or their representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to the MO HealthNet Program may result in recovery of the payments for those services not adequately documented and may result in sanctions to the provider’s participation in the MO HealthNet Program. This policy continues to apply in the event of the provider’s discontinuance as an actively participating MO HealthNet provider through change of ownership or any other circumstance. The provider must make records available for unannounced inspections and audits, with access during normal business hours by the Departments of Social Services and Health and Senior Services or the U.S. Department of Health and Human Services.

13.7.D ADEQUATE DOCUMENTATION

All services provided must be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3 defines “adequate documentation” and “adequate medical records” as follows:

Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered.
13.7.D(1) Required Documentation

The following are the requirements for the documentation of services rendered.

1. The date of the service.

2. The time spent providing the service. Time spent must be documented by one of the following methods:

   • Actual clock time of the start and actual clock time of the end of any period of uninterrupted one-on-one service to a single individual is documented. For example, if a personal care aide is providing services to one individual in a private home setting and devotes undivided attention to the care required by that individual, the actual clock time the aide began the services for that visit is the start time, and the actual clock time the aide finished the care for the visit is the stop time. (Example—Time spent: 9:30 a.m. to 10:30 a.m.) IF more than one visit per day is required, each separate visit has a start and a stop clock time noted. This method may also be used in a setting where the aide is providing care to and dividing his or her attention among several individuals. The actual clock start and stop time for each period of uninterrupted service for each individual is clearly documented.

   • Pursuant to RSMo 660.023, all in-home services provider agencies shall by July 1, 2015, have, maintain, and use a telephone tracking system for the purpose of reporting and verifying the delivery of home and community-based services as authorized by the Department of Health and Senior Services. At a minimum, the telephone tracking system shall: record the exact date services are delivered; record the exact time the services begin and exact time the services end; verify the telephone number from which the services were registered; verify the number from which the call is placed is a telephone number unique to the client; require a personal identification number unique to each personal care attendant; and be capable of producing reports of services delivered, tasks performed, client identity, beginning and ending times of services and date of service in summary fashion that constitute adequate documentation of service. Telephony approval may be obtained by the provider submitting a written request to Missouri Medicaid Audit and Compliance Unit (MMAC), P.O. Box 6500, Jefferson City, MO 65402. The request must include the name of the company that will be used to provide the telephony service and the expected start date.
Final approval to participate will require the provider to enter an addendum to their current participation agreement with MMAC.

- When the personal care services are provided in congregate living settings, such as a Residential Care Facility (RCF) or Assisted Living Facility (ALF), personal care aide staff will divide their time among a number of individuals, the following must be documented: all tasks performed for each participant by date of service and by staff shifts during each 24 hour period.

- Any other method that includes all required elements of documentation listed in this section.

3. A description of the service (specific tasks).
4. The name of the personal care aide who provided the service.
5. The participant’s name and MO HealthNet number.
6. For each date of service: the signature of the participant, or the mark of the participant witnessed by at least one person, or the signature of another responsible person present in the participant’s home or licensed Residential Care Facility (RCF) or Assisted Living Facility (ALF) at the time of service. A responsible person may include the personal care aide’s supervisor, if the supervisor is present in the home or licensed RCF or ALF at the time of service delivery. The personal care aide may only sign on behalf of the participant when the participant is unable to sign and there is no other responsible person present. The entire signature of the participant or witness to the mark or the responsible party must be present in the record for each date of service billed to MO HealthNet. Initials are not acceptable in lieu of the entire signature.

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

DHSS assumes a 31-day month in calculating the monthly maximum number of personal care units for which each participant is eligible. However, several plans of care assign tasks to be performed seven times per week (daily); and, several
months in the year contain fewer than 31 days. For RCF and ALF personal care providers, when a participant’s plan of care includes at least one task that is to be performed daily, then the participant’s monthly maximum allotment cannot be reached in a month containing fewer than 31 days. When determining compliance with this limitation, the following steps may be used to manually calculate the monthly authorization:

**NOTE: This only pertains to RCF and ALF Personal Care providers.**

Step 1: Identify the daily tasks (tasks shown on the care plan as daily or with a frequency of 7 times a week).

Step 2: Identify the total number of minutes for these daily tasks in a week (this may appear directly on the care plan, or determined by multiplying the total number of daily task minutes by 7).

Step 3: Divide the number in step 2 by 15. Round up to the nearest whole number (.5 or more rounds up). This will equal the daily task units per week.

Step 4: Divide the number in step 3 by 7. Round up to the nearest whole number (.5 or more rounds up). This will equal the daily task units per day.

Step 5: Multiply the number in step 4 by the number of days fewer than 31 in the month. (Take the number from step 4 and multiply it by 1 for April, June, September, and November. Multiply it by 3 for February. Multiply it by 2 for February in a leap year.)

Step 6: Take the total from step 5 and subtract it from the total number of authorized units. This will equal the new total of authorized units for the shorter month.

13.7.D(2) Unit of Service

A unit of personal care service is 15 minutes of direct service to the participant, including time spent completing work vouchers and obtaining participant signatures. Time spent for travel, lunch, breaks, or administrative activities such as completing other reports or paperwork shall not be included.

13.7.D(3) Accrued Units

Personal care providers may bill up to one full month of service on one detail line of a claim. It is permissible to accrue partial units of less than 15 minutes for several dates of service and bill the total, in whole units (15 minutes), at the end of the day, week, or month, as long as care delivery is consistent with the written plan of care.

PRODUCTION: 11/21/2018
The following instructions apply to billing accrued units on separate detail lines of a claim:

- When billing each date of service, partial units may be accrued and billed on the first date a whole unit is accrued. For example, a provider delivers care from 10:00 to 11:40 on June 1, then provides care from 10:00 to 12:10 on June 4. Six units of service are billed for June 1, and 9 units of service are billed on June 4.

- When billing multiple dates of service on one detail line of a claim, total the time spent in minutes for each date, divide by 15, and bill the number of whole units. Do not round up to the nearest whole unit. For example, at the end of the month, time spent in the provision of personal care to an individual in a congregate living facility, who received services every day, totals 620 minutes. 620/15={41.33} units. Bill for 41 whole units of service.

• When billing multiple dates of service on one detail line of a claim, dates during which the client is in a hospital, in a nursing home facility, visiting relatives or is ineligible should not be included in the range of dates.

• When billing multiple dates of service on one detail line of a claim, do not bill for dates of service falling in two separate calendar months.

13.8 THE AUTHORIZED NURSE VISIT

The authorized nurse visit is a covered service under the MO HealthNet Personal Care Program. Reimbursement is made for supervision of the Personal Care Program, in addition to the visits by a nurse to particular participants with special needs, when such visits are prior authorized by the Department of Health and Senior Services' Division of Senior and Disability Services or its designee, or Bureau of Special Health Care Needs.

Providers of personal care services must have the capacity to provide these authorized nurse visits as well as the non-authorized nurse supervision requirements outlined in the Personal Care Program standards.

The nursing services that may be authorized in the participant’s home are services of a maintenance or preventative nature provided to participants with stable, chronic conditions. These services are not intended as treatment for an acute health condition and may not include services that are reimbursable as skilled nursing care under either the Medicare or MO HealthNet Home Health Programs. Should the provider nurse detect a need for services that meet the definition of reimbursable skilled nursing care under the Home Health Program, the provider nurse must alert the participant’s physician and the appropriate state agency or its designee. The physician may then refer the participant to a home health agency for treatment.
13.8.A PARTICIPANT ELIGIBILITY

To be eligible for the authorized nurse visit, the participant must receive a personal care service and have a documented need for the authorized nurse visit and have no adequate support system that could provide these services to the participant.

Authorized nurse visits are limited to 26 within a 6-month time frame.

13.8.B SERVICES WHICH MAY BE AUTHORIZED

The services of the nurse shall provide increased supervision to the personal care aide and maintenance or preventative services, assessment of the participant’s health and the suitability of the service plan to meet the participant’s needs. All advanced personal care participants must have at least one authorized nurse visit per month. These services shall also include any referrals or follow-up action indicated by the nurse’s assessment. In addition, these services must include one or more of the following where appropriate to the needs of the participant and authorized by the appropriate state agency:

- Filling a one-week supply of insulin syringes for a diabetic who can self-inject the medication but cannot fill his own syringe. This service includes monitoring the participant’s continued ability to self-administer the insulin. If the participant is otherwise eligible for services reimbursed through the Home Health Program, the authorized nurse visit through the Personal Care Program to pre-fill the syringes is not appropriate, since the service could and would be provided by the home health nurse;
  
  NOTE: Manufacturers recommend that certain insulin should not be pre-filled into syringes.

- Setting up oral medications in divided daily compartments for a participant who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

- Monitoring a participant’s skin condition when a participant is at risk of skin breakdown.

- Conducting health evaluations;

- Providing nail care for the diabetic participant with other medically contraindicating conditions who is unable to perform this task, such as:
  
  - Circulatory or neurologic deficiency;
  - Taking anticoagulant medications, such as Coumadin;
  - Diagnosed with peripheral vascular disease; or
  - Diagnosed with compromised immune system, i.e., HIV and chemotherapy.
• Making a monthly on-site visit to each participant for whom advanced personal care services are authorized to evaluate the condition of the participant. A monthly visit report is documented through a provider general health evaluation and level of care recommendation form. This document must be maintained in the participants file. If critical issues are found during this on-site visit, the HCBS Regional Evaluation (REV) Team must be contacted immediately. The Semi-annual General Health Assessment form must be forwarded to the appropriate HCBS REV Team after completion. If critical issues are found during the semi-annual General Health Assessment the HCBS REV Team must be contacted immediately;

• Providing on-the-job training and competency testing for advanced personal care aides.

The state agency or its designee, at their discretion, may recommend authorization of nurse visits in other situations.

The authorized nurse visits listed above may be provided by an LPN, if under the direction of an RN or physician, except an RN must perform the on-the-job training and competency testing for advanced personal care aides. The services provided during the authorized nurse visit shall not include any service which the participant is eligible to receive under either the Medicare (Title XVIII) or MO HealthNet (Title XIX) Home Health Programs. The services listed above do not qualify, by themselves, for reimbursement under either program. However, should a participant otherwise be eligible for home health services, then the following services: filling a one week supply of insulin syringes, setting up oral medications in divided daily compartments, monitoring a participant’s skin condition when the participant is at risk of skin breakdown and nail care for a diabetic or a participant with other medically contraindicating conditions, will be provided by the home health agency.

It is the responsibility of the nurse to contact the participant’s physician to obtain any necessary information or orders pertaining to the care of the participant. If the participant has an ongoing need for service activities that require more or less units than authorized, the nurse shall recommend in writing, that the plan of care be revised.

13.8.C AUTHORIZED NURSE ADMINISTRATIVE REQUIREMENTS

The following administrative requirements must be maintained whenever the authorized nurse services are delivered. These requirements are in addition to the administrative standards of the Personal Care Program outlined in Section 13.2.

The provider shall provide a general orientation for the nurse prior to the delivery of services which shall include instruction on the following:

• Code of ethics;
• Participant’s bill of rights;
• Activities which shall or shall not be performed;
• Infection control and universal precaution procedures as defined by the Centers for Disease Control;
• Record keeping requirements and reporting forms required by the personal care provider or state agency, or its designee who authorized the service;
• Occupational Safety Hazards Administration standards regarding precautions to be taken to avoid risks associated with bloodborne pathogens; and
• Communicating with the appropriate state agency or its designee and taking appropriate action on clinical changes in the participant’s condition.

13.8.D AUTHORIZED NURSE VISIT RECORDS

Written notes concerning the authorized nurse’s visits must be maintained in the participant’s file. In addition, notes of any verbal communication and copies of any written communications with the participant’s physician, other health care professional, or state agency, or its designee, concerning the care of that participant, is also maintained in the participant’s file.

13.9 ADVANCED PERSONAL CARE SERVICES

The provision of advanced personal care services is an option available to providers under the MO HealthNet Personal Care Program. These advanced personal care tasks are maintenance services provided to assist a participant with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body functions.

Advanced personal care is a maintenance service and should never be used as a therapeutic treatment. Participants who develop medical complications requiring skilled nursing services while receiving advanced personal care services shall be referred to their attending physician who may, if appropriate, order home health services, inpatient care, or institutionalization.

All personal care standards set forth in Section 13 also apply to the Advanced Personal Care Program unless specifically stated otherwise. The requirements contained in this section are in addition to the Personal Care Program standards and pertain only to the delivery of advanced personal care services.

13.9.A SERVICE DESCRIPTION

Examples of advanced personal care services that may be performed are:

• Routine personal care for persons with ostomies (including tracheostomies, gastrostomies and colostomies with well-healed stoma) and external, indwelling, and suprapubic catheters. This care includes changing bags, and soap and water hygiene around ostomy or catheter site;
• Remove external catheters; inspect skin and reapplication of same;

PRODUCTION: 11/21/2018

183
• Administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (pre-packaged only) for participants without contraindicating rectal or intestinal conditions;
• Apply medicated (prescription) lotions or ointments, and dry, non-sterile dressing to unbroken skin;
• Use lift, or other device, for transfers;
• Manually assist with oral medications which are set up by a registered or licensed practical nurse;
• Provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology; and
• Apply non-sterile dressings to superficial skin breaks or abrasions as directed by a registered or licensed practical nurse.

Personal care providers choosing to offer advanced personal care are required to provide all of the above listed services.

13.9.B PROVIDER PARTICIPATION REQUIREMENTS

Providers choosing to deliver advanced personal care services must have a valid MO HealthNet Personal Care Provider Agreement in effect with the Missouri Medicaid Audit and Compliance Unit (Section 13.1.D). In addition, the provider must sign an addendum to their Title XIX Personal Care Provider Agreement, indicating their agreement to provide advanced personal care services.

Only those personal care providers meeting one of the following requirements may sign the addendum; and subsequently, be authorized to provide advanced personal care:

A. Title XX (Social Service Block Grant) providers whose contract includes advanced personal care.

B. A Residential Care Facility (RCF) or Assisted Living Facility (ALF) licensed by the Division of Regulation and Licensure.

Upon approval of the advanced personal care provider application, RCF/ALF advanced personal care providers may only furnish advanced personal care services to participants in their RCF/ALF. If an RCF/ALF provider wants to provide advanced personal care services in the community it must submit a proposal to Missouri Medicaid Audit and Compliance Unit (MMAC) P.O. Box 6500, Jefferson City, MO 65102-6500, and must receive approval as a Title XX (Social Service Block Grant (SSBG)) provider before services can be approved. Providers may contact MMAC at (573) 751-3399 for information regarding the SSBG provider program.

PRODUCTION: 11/21/2018
The addendum and verification of the Title XX contract should be submitted to the MMAC Provider Enrollment Unit, P.O. Box 6500, Jefferson City, Missouri 65102-6500. Click here for a copy of the MO HealthNet Advanced Personal Care Program Addendum to Title XIX Participation Agreement for Personal Care Services.

13.9.C PARTICIPANTS MINIMUM NEEDS CRITERIA

In addition to meeting the eligibility requirements of the Personal Care Program (Section 13.1.E), the participant must have a documented need for the advanced personal care service(s) and have no adequate support system that could provide these services to the participant. The participant must have a qualifying altered body function, etc. as described in Section 13.9. Participants are assessed as eligible for personal care or advanced personal care by one of the appropriate state agencies, the Department of Health and Senior Services' Division of Senior and Disability Services or its designee, the Division of Community and Public Health (DCPH), Bureau of HIV, STD, and Hepatitis, and Bureau of Special Health Care Needs (BSHCN). (For children and for persons with AIDS/HIV, see Section 13.15.G and Section 13.16.)

13.9.D AUTHORIZATION OF ADVANCED PERSONAL CARE

All units of advanced personal care must be authorized by the state agency or its designee before services can be delivered. The plan of care must be developed, reviewed, and updated by the provider's RN in cooperation with state agency or its designee. For advanced personal care services authorized by BSHCN for children (age 0-20 yr. old), the advanced personal care plan must be updated every six months.

13.9.E ADVANCED PERSONAL CARE RN SUPERVISION

RN supervision is essential to the safe provision of advanced personal care services. Certain nurse functions for advanced personal care participants may be performed by a licensed practical nurse; others must be performed by a registered nurse. The following outlines the nursing requirements for advanced personal care participants:

The registered nurse must:

• conduct an initial assessment visit and develop the plan of care for participants with advanced personal care needs, in collaboration with the state agency staff or its designee. The provider may request a change in the care plan if determined through this initial assessment. This request should be made to the appropriate Department of Health and Senior Services (DHSS) staff. This visit may be authorized and billed to MO HealthNet as an authorized nurse visit.

• conduct on-site visits to all advanced personal care participants at intervals no greater than six months. During the visit, the RN must conduct and contemporaneously record
and certify by his/her signature an individualized evaluation of the participant’s condition, the adequacy of the authorized services to meet the needs and conditions of the participant, including a review of the care plan with the participant.

- be available, at least by telephone, during any period of time advanced personal care is being provided.

- observe the successful execution by the aide of each advanced personal care task during an on-the-job training session, and certify the successful completion of the task in the aide’s personnel record. This visit may be authorized and reimbursed.

The licensed practical nurse may, under the direction of a registered nurse:

- conduct the monthly authorized nurse visit to evaluate the condition of the advanced personal care participant and the adequacy of the care plan to meet the needs and conditions of the participant, including a review of the care plan with the participant.

13.9.F ADVANCED PERSONAL CARE AIDE REQUIREMENTS

In addition to meeting the basic personal care aide requirements discussed in Section 13.3.B of this manual, all advanced personal care aides employed by the provider must:

- be an LPN or a certified nurse assistant;

- be a competency evaluated home health aide having completed both written demonstration portions of the test required by the Missouri Department of Health and Senior Services and 42 CFR 484.36; or have successfully worked for the provider for a minimum of three consecutive months while working at least fifteen hours per week as an in-home aide that has received personal care training.

13.9.G ADVANCED PERSONAL CARE AIDE TRAINING

Advanced personal care aides must receive eight classroom hours of advanced personal care training in addition to the required basic training for personal care aides as described in this manual. The provider shall have written plans of the classroom training; such training must include at least a minimum the following topics:

- observation of the participant and reporting observations;
- application of ointments/lotions to broken skin;
- manual assistance with oral medications;
- prevention of decubiti;
- enemas;
- basic personal care for persons with ostomies and catheters;
- proper cleaning of catheter bags;
- bowel routines (rectal suppositories, sphincter stimulation);

PRODUCTION: 11/21/2018
• passive range of motion exercises;
• use of assistive device (i.e., lifts, transfer boards, etc.) for transfers;
• positioning and support of the participant;
• applying non-sterile dressings to superficial skin breaks; and
• universal precaution procedures as defined by the Centers for Disease Control.

The provider must document the dates and hours of the eight classroom hours of advanced personal care training received by the personal care aide in the aide’s personnel file.

13.9.G(1) Waiver of Classroom Hours

The provider may waive the eight classroom hours of advanced personal care training if the following conditions are met:

• the advanced personal care aide is a certified nurse assistant or a licensed practical nurse currently licensed or registered in the state of Missouri; or

• the personal care aide has previously completed advanced personal care training from a Missouri Medicaid in-home provider agency contracted with Missouri Medicaid Audit and Compliance Unit in-home provider; and

• the personal care aide has been employed at least half time by a Missouri Medicaid in-home provider as an advanced personal care aide within the prior six (6) months.

If the waiver of advanced personal care training has been granted, documentation that the above conditions have been met must be placed in the aide’s personnel record and available for inspection.

13.9.G(2) Demonstration of Competency

Prior to performing any advanced personal care task for any participant for the first time, the advanced personal care aide who is not a licensed nurse must demonstrate competency, specifically for the advanced personal care tasks as they appear on a participant’s plan of care. This competency must be demonstrated in an on-the-job training session conducted by the registered nurse. The registered nurse must document the aide’s competency in performing each task in the aide’s personnel file. The required demonstration of each advanced personal care task during an on-the-job training session with an RN may not be waived. RN visits necessary for task observation and certification in the home may be prior authorized and billed to MO HealthNet as an authorized nurse visit. RN task observation and certification in a laboratory, or other non-home setting, may not be billed.
The RN must observe the aide performing the following tasks in the participant’s home:

- routine personal care of persons with ostomies (including tracheostomies, gastrostomies, colostomies all with well-healed stoma) which includes changing bags, and soap and water hygiene around ostomy site;
- personal care of persons with external, indwelling, and suprapubic catheters which includes changing bags, and soap and water hygiene around site;
- removal of external catheters, inspect skin and reapply catheter;
- administration of prescribed bowel programs, including use of suppositories and sphincter stimulation per protocol and enemas (prepackaged only) for participants without contraindicating rectal or intestinal conditions;
- use of assistive device for transfers.

The RN may observe the following tasks in the home or lab setting.

- application of medicated (prescription) lotions, ointments or dry, aseptic dressings to unbroken skin including stage I decubitus;
- application of aseptic dressings to superficial skin breaks or abrasions as directed by a licensed nurse;
- manual assistance with noninjectable medications as set up by a licensed nurse;
- passive range of motion (nonresistive flexion of joint with normal range) delivered in accordance with the care plan.

13.9.G(3) Annual In-Service Training

Advanced personal care aides must also receive ten (10) hours of annual in-service training, the same as any personal care aide (see In-Service Training 13.6.E).

13.9.H ADVANCED PERSONAL CARE RECORDS

Providers participating in the delivery of advanced personal care services must maintain all records and documentation required of the MO HealthNet Personal Care Program. In addition, the following records and documentation that pertain only to the delivery of advanced personal care services must be maintained by participating providers.

13.9.H(1) Aide’s Personnel Record

The personal care aide’s personnel record shall contain:

- Documentation of the eight classroom hours of advanced personal care training including dates and topics;

PRODUCTION: 11/21/2018
• Documentation for any waiver of the eight (8) classroom hours of advanced personal care training; and

• Signed statement(s) by the RN certifying that the personal care aide has successfully completed on-the-job training for each advanced personal care task the aide is required to perform.

13.9.H(2)  Participant’s Record

The case record of any participant receiving advanced personal care services shall include:

• Written notes concerning any authorized nurse visits including the six month supervisory visit and the monthly nurse visit report. In addition, notes of any verbal communication and copies of any written communication with the participant’s physician or other health care professional, concerning the participant’s care must be maintained in the participant’s case record.

• A closing summary documenting that 21 day notification was given to the state agency or its designee, and the advanced personal care participant prior to the date of closing, the participant’s authorization date, the most recent care plan including identified functional disabilities, the reason for closing, the date of closing, and a follow-up plan, if applicable.

13.10 GENERAL INFORMATION – PERSONAL CARE ASSISTANCE – CONSUMER-DIRECTED SERVICES (CDS) OPTION

The Personal Care Assistance—Consumer-Directed Services (CDS) Personal Assistance (PCA) program is authorized by the Department of Health and Senior Services/Division of Senior and Disability Services(DHSS)/(DSDS).

13.10.A  SERVICE DEFINITION

Personal Care Assistance - CDS are services that are required or may be provided as part of the CDS program.

Under CDS, the participant is responsible for hiring, training, supervising, and directing the personal care attendant.

Authorization of CDS is funded through both the Medicaid state plan and the Independent Living Waiver (ILW). This policy addresses the Medicaid state plan services only.

13.10.B  PERSONAL CARE TASKS

CDS Personal Care tasks include but are not limited to:

• Bathing, including shampooing hair:
Checking Requirements

Entities required to check the EDL under Section 192.2490:

1. Licensed as operator under Chapter 198
2. Provide in-home services under contract with the department
3. Temporary nurse staffing agencies
4. Nursing assistant training agency
5. Licensed under Chapter 197 (hospitals, ambulatory surgical centers, hospices, home health agencies).

Under Section 192.2490 (http://www.moga.mo.gov/mostatutes/stathtml/19200024901.html), these entities are prohibited from knowingly hiring a person, for any type of position, whose name appears on the EDL. These entities must, at a minimum, check the latest annual EDL and quarterly updates, available on this web site, before hiring any person for any job. An annual list is available in January of each year. Updates are added to the web site each quarter which list all individuals who have been added to or deleted from the EDL during the preceding three months. The annual EDL and quarterly updates are organized alphabetically by last name and by social security number.

Entities defined as 'providers' under Section 192.2495 (http://www.moga.mo.gov/mostatutes/stathtml/19200024951.html):

1. Licensed as operator under Chapter 198
2. Provide in-home services under contract with the department
3. Temporary nurse staffing agencies
4. Licensed under Chapter 197 (hospitals, ambulatory surgical centers, hospices, home health agencies)
5. Public or private facility, day program, residential facility or specialized service operated, funded or licensed by the department of mental health
6. Licensed adult day care.

This section differs significantly from 192.2490. Prior to allowing any person who has been hired to have any contact with any patient or resident, "providers" are required to make an inquiry to the department of health and senior services whether an individual is on the EDL. Section 192.2495 does not prohibit the provider from employing anyone on the EDL; it simply says the provider has to inquire. The EDL employment prohibition remains exclusively in Section 192.2490.

Taking the two sections together, all entities listed in Section 192.2490 are to check the EDL (at a minimum, the annual EDL report and quarterly updates available on this web site.) before hiring a person in any capacity. Before allowing an employee to have contact with patients or residents, providers listed under Section 192.2495, must also make an affirmative inquiry to the Department whether the person is on the EDL. Entities listed in 192.2490 cannot hire someone and wait until they are ready to have patient or resident contact before they check the EDL, but they do not have to do the affirmative inquiry before hiring. If an entity chooses to initiate an affirmative inquiry before hiring any new employee, they've met the requirements of both Sections 192.2490 and 192.2495 for checking the EDL.

In addition to the preemployment EDL checks, entities listed in 192.2490 must also check all their current employees against each quarterly EDL update to assure that no one employed, in any capacity has been added to the EDL since the initial EDL check. Monthly EDL checks on all employees are not required.
Employee Disqualification List (EDL)

- Check EDL
- Access Request Form (pdf/accessrequestform.pdf)
- Access to Automated System (instructions.php#access)
- Confidentiality (instructions.php#confidentiality)
- Deletion of Users (instructions.php#deletion)

Checking Requirements (checkrequirements.php)
- Laws (laws.php)
- Family Care Safety Registry (FCSR) (https://health.mo.gov/safety/fcsr/index.php)
- Consumer Reporting Agencies (consumerreportingagencies.php)

The Employee Disqualification List (EDL) maintained by the Department of Health and Senior Services is a listing of individuals who have been determined to have:

A. abused or neglected a resident, patient, client, or consumer;
B. misappropriated funds or property belonging to a resident, patient, client, or consumer; or
C. falsified documentation verifying delivery of services to an in-home services client or consumer.

These acts must have occurred while the individual was employed or by reason of their employment by a long-term care facility, an in-home services provider agency, by a hospital, home health agency, hospice, or ambulatory surgical center, or by a consumer or vendor.

Individuals are notified that an investigation has indicated that they have committed acts of abuse, neglect, misappropriation or falsification and they are given an opportunity to appeal before being placed on the EDL.

Long-term care facilities, in-home services provider agencies, hospitals, home-health agencies, hospices and ambulatory surgical centers are prohibited from employing a person, in any capacity, whose name appears on the EDL. These providers are required to check the EDL before hiring an individual and they may not continue to employ a person whose name appears on the EDL.

Section 208.909 RSMo (http://www.moga.mo.gov/mostatutes/stathtml/208000090901.html), prohibits the authorization or expenditure of any state or federal financial assistance to pay for personal care assistance services provided by a personal care attendant who is listed on any of the background check lists in the Family Care Safety Registry under Sections 210.900 to 210.933, RSMo, unless a Good Cause Waiver is obtained pursuant to Section 660.317, RSMo. Please note, however, that good cause waivers cannot be obtained for individuals whose names are included on the EDL.

Section 630.170, RSMo (http://www.moga.mo.gov/mostatutes/stathtml/63000001701.html), also disqualifies any person whose name appears on the EDL from holding any position in any public or private facility or day program operated, funded or licensed by the Department of Mental Health (http://dmh.mo.gov/hr/disqualify.htm) or in any mental health facility or mental health program in which people are admitted on a voluntary or involuntary basis or are civilly detained pursuant to Chapter 632, RSMo (http://www.moga.mo.gov/mostatutes/ChaptersIndex/chaptIndex632.html).

EDL is available through the EDL website (webinstructions.php)

- EDL web site (webinstructions.php)

ACCESS
All entities listed in sections 208.909 (http://www.moga.mo.gov/mostatutes/stathtml/20800009091.html), 192.2490 (http://www.moga.mo.gov/mostatutes/stathtml/19200024901.html) and 192.2495 (http://www.moga.mo.gov/mostatutes/stathtml/19200024951.html) RSMo required to check the EDL are allowed to access the annual EDL report and quarterly updates available on the web site.

1. An entity licensed as an operator under Chapter 198, RSMo (skilled nursing facilities, intermediate care facilities, residential care facilities I and II);
2. An entity which provides in-home services under contract with DHSS;
3. An entity which employs nurses and nursing assistants for temporary or intermittent placement in health care facilities (temporary staffing agencies);
4. An entity approved by DHSS to issue certificates for nursing assistants' training; or
5. An entity licensed under Chapter 197, RSMo (hospitals, ambulatory surgical centers, hospices, home health care agencies);
6. A public or private facility, day program, residential facility or specialized service operated, funded or licensed by the Department of Mental Health;
7. A licensed adult day care provider;
8. A vendor as defined in Section 208.900, RSMo (http://www.moga.mo.gov/mostatutes/stathtml/20800009091.html).

The information on EDL is confidential and available only to the entities specified by law for employment purposes. The information may not be further released by the entity obtaining the information.

The EDL system will allow verification of the EDL status of applicants for employment and provide a confirmation number as confirmation that the required EDL check was performed. The EDL website is available for site visits seven days a week, 22 hours per day. System maintenance occurs between 2 a.m. and 4 a.m., each day.

webpage: https://health.mo.gov/safety/edl/index.php
Summary of the HIPAA Security Rule

This is a summary of key elements of the Security Rule including who is covered, what information is protected, and what safeguards must be in place to ensure appropriate protection of electronic protected health information. Because it is an overview of the Security Rule, it does not address every detail of each provision.

Introduction

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. To fulfill this requirement, HHS published what are commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The Privacy Rule, or Standards for Privacy of Individually Identifiable Health Information, establishes national standards for the protection of certain health information. The Security Standards for the Protection of Electronic Protected Health Information (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form. The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that organizations called "covered entities" must put in place to secure individuals' "electronic protected health information" (e-PHI). Within HHS, the Office for Civil Rights (OCR) has responsibility for enforcing the Privacy and Security Rules with voluntary compliance activities and civil money penalties.

Prior to HIPAA, no generally accepted set of security standards or general requirements for protecting health information existed in the health care industry. At the same time, new technologies were evolving, and the health care industry began to move away from paper processes and rely more heavily on the use of electronic information systems to pay claims, answer eligibility questions, provide health information and conduct a host of other administrative and clinically based functions.

Today, providers are using clinical applications such as computerized physician order entry (CPOE) systems, electronic health records (EHR), and radiology, pharmacy, and laboratory systems. Health plans are providing access to claims and care management, as well as member self-service applications. While this means that the medical workforce can be more mobile and efficient (i.e., physicians can check patient records and test results from wherever they are), the rise in the adoption rate of these technologies increases the potential security risks.
A major goal of the Security Rule is to protect the privacy of individuals' health information while allowing covered entities to adopt new technologies to improve the quality and efficiency of patient care. Given that the health care marketplace is diverse, the Security Rule is designed to be flexible and scalable so a covered entity can implement policies, procedures, and technologies that are appropriate for the entity's particular size, organizational structure, and risks to consumers' e-PHI.

This is a summary of key elements of the Security Rule and not a complete or comprehensive guide to compliance. Entities regulated by the Privacy and Security Rules are obligated to comply with all of their applicable requirements and should not rely on this summary as a source of legal information or advice. To make it easier to review the complete requirements of the Security Rule, provisions of the Rule referenced in this summary are cited in the end notes. Visit our Security Rule section to view the entire Rule, and for additional helpful information about how the Rule applies. In the event of a conflict between this summary and the Rule, the Rule governs.

Statutory and Regulatory Background

- The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Secretary of HHS to publish national standards for the security of electronic protected health information (e-PHI), electronic exchange, and the privacy and security of health information.

HIPAA called on the Secretary to issue security regulations regarding measures for protecting the integrity, confidentiality, and availability of e-PHI that is held or transmitted by covered entities. HHS developed a proposed rule and released it for public comment on August 12, 1998. The Department received approximately 2,350 public comments. The final regulation, the Security Rule, was published February 20, 2003. The Rule specifies a series of administrative, technical, and physical security procedures for covered entities to use to assure the confidentiality, integrity, and availability of e-PHI.

The text of the final regulation can be found at 45 CFR Part 160 and Part 164, Subparts A and C.

Who is Covered by the Security Rule

- The Security Rule applies to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form in connection with a transaction for which the Secretary of HHS has adopted standards under HIPAA (the "covered entities") and to their business associates. For help in determining whether you are covered, use CMS's decision tool.

Read more about covered entities in the Summary of the HIPAA Privacy Rule - PDF - PDF.

Business Associates

- The HITECH Act of 2009 expanded the responsibilities of business associates under the HIPAA Security Rule. HHS developed regulations to implement and clarify these changes.

See additional guidance on business associates.

What Information is Protected
• **Electronic Protected Health Information.** The HIPAA Privacy Rule protects the privacy of individually identifiable health information, called protected health information (PHI), as explained in the Privacy Rule and [here - PDF - PDF](#). The Security Rule protects a subset of information covered by the Privacy Rule, which is all individually identifiable health information a covered entity creates, receives, maintains or transmits in electronic form. The Security Rule calls this information “electronic protected health information” (e-PHI).³ The Security Rule does not apply to PHI transmitted orally or in writing.

**General Rules**

• The Security Rule requires covered entities to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting e-PHI. Specifically, covered entities must:

1. Ensure the confidentiality, integrity, and availability of all e-PHI they create, receive, maintain or transmit;

2. Identify and protect against reasonably anticipated threats to the security or integrity of the information;

3. Protect against reasonably anticipated, impermissible uses or disclosures; and

4. Ensure compliance by their workforce.⁴

The Security Rule defines “confidentiality” to mean that e-PHI is not available or disclosed to unauthorized persons. The Security Rule’s confidentiality requirements support the Privacy Rule’s prohibitions against improper uses and disclosures of PHI. The Security rule also promotes the two additional goals of maintaining the integrity and availability of e-PHI. Under the Security Rule, “integrity” means that e-PHI is not altered or destroyed in an unauthorized manner. “Availability” means that e-PHI is accessible and usable on demand by an authorized person.⁵

HHS recognizes that covered entities range from the smallest provider to the largest, multi-state health plan. Therefore the Security Rule is flexible and scalable to allow covered entities to analyze their own needs and implement solutions appropriate for their specific environments. What is appropriate for a particular covered entity will depend on the nature of the covered entity’s business, as well as the covered entity’s size and resources.

Therefore, when a covered entity is deciding which security measures to use, the Rule does not dictate those measures but requires the covered entity to consider:

- Its size, complexity, and capabilities,

- Its technical, hardware, and software infrastructure,

- The costs of security measures,
- The likelihood and possible impact of potential risks to e-PHI.\textsuperscript{6}

Covered entities must review and modify their security measures to continue protecting e-PHI in a changing environment.\textsuperscript{7}

**Risk Analysis and Management**

- The Administrative Safeguards provisions in the Security Rule require covered entities to perform risk analysis as part of their security management processes. The risk analysis and management provisions of the Security Rule are addressed separately here because, by helping to determine which security measures are reasonable and appropriate for a particular covered entity, risk analysis affects the implementation of all of the safeguards contained in the Security Rule.

- A risk analysis process includes, but is not limited to, the following activities:
  - Evaluate the likelihood and impact of potential risks to e-PHI;\textsuperscript{8}
  - Implement appropriate security measures to address the risks identified in the risk analysis;\textsuperscript{9}
  - Document the chosen security measures and, where required, the rationale for adopting those measures;\textsuperscript{10} and
  - Maintain continuous, reasonable, and appropriate security protections.\textsuperscript{11}

Risk analysis should be an ongoing process, in which a covered entity regularly reviews its records to track access to e-PHI and detect security incidents,\textsuperscript{12} periodically evaluates the effectiveness of security measures put in place,\textsuperscript{13} and regularly reevaluates potential risks to e-PHI.\textsuperscript{14}

**Administrative Safeguards**

- **Security Management Process.** As explained in the previous section, a covered entity must identify and analyze potential risks to e-PHI, and it must implement security measures that reduce risks and vulnerabilities to a reasonable and appropriate level.

- **Security Personnel.** A covered entity must designate a security official who is responsible for developing and implementing its security policies and procedures.\textsuperscript{15}

- **Information Access Management.** Consistent with the Privacy Rule standard limiting uses and disclosures of PHI to the "minimum necessary," the Security Rule requires a covered entity to implement policies and procedures for authorizing access to e-PHI only when such access is appropriate based on the user or recipient's role (role-based access).\textsuperscript{16}

- **Workforce Training and Management.** A covered entity must provide for appropriate authorization and supervision of workforce members who work with e-PHI.\textsuperscript{17} A covered entity must train all workforce members regarding its security policies and procedures,\textsuperscript{18} and must have and apply appropriate sanctions against workforce members who violate its policies and procedures.\textsuperscript{19}
• **Evaluation.** A covered entity must perform a periodic assessment of how well its security policies and procedures meet the requirements of the Security Rule.  

**Physical Safeguards**

• **Facility Access and Control.** A covered entity must limit physical access to its facilities while ensuring that authorized access is allowed.

• **Workstation and Device Security.** A covered entity must implement policies and procedures to specify proper use of and access to workstations and electronic media. A covered entity also must have in place policies and procedures regarding the transfer, removal, disposal, and re-use of electronic media, to ensure appropriate protection of electronic protected health information (e- PHI).

**Technical Safeguards**

• **Access Control.** A covered entity must implement technical policies and procedures that allow only authorized persons to access electronic protected health information (e- PHI).

• **Audit Controls.** A covered entity must implement hardware, software, and/or procedural mechanisms to record and examine access and other activity in information systems that contain or use e- PHI.

• **Integrity Controls.** A covered entity must implement policies and procedures to ensure that e- PHI is not improperly altered or destroyed. Electronic measures must be put in place to confirm that e- PHI has not been improperly altered or destroyed.

• **Transmission Security.** A covered entity must implement technical security measures that guard against unauthorized access to e- PHI that is being transmitted over an electronic network.

**Required and Addressable Implementation Specifications**

• Covered entities are required to comply with every Security Rule "Standard." However, the Security Rule categorizes certain implementation specifications within those standards as "addressable," while others are "required." The "required" implementation specifications must be implemented. The "addressable" designation does not mean that an implementation specification is optional. However, it permits covered entities to determine whether the addressable implementation specification is reasonable and appropriate for that covered entity. If it is not, the Security Rule allows the covered entity to adopt an alternative measure that achieves the purpose of the standard, if the alternative measure is reasonable and appropriate.

**Organizational Requirements**

• **Covered Entity Responsibilities.** If a covered entity knows of an activity or practice of the business associate that constitutes a material breach or violation of the business associate’s obligation, the covered entity must take reasonable steps to cure the breach or end the violation. Violations include the failure to implement safeguards that reasonably and appropriately protect e- PHI.
• **Business Associate Contracts.** HHS developed regulations relating to business associate obligations and business associate contracts under the HITECH Act of 2009.

**Policies and Procedures and Documentation Requirements**

• A covered entity must adopt reasonable and appropriate policies and procedures to comply with the provisions of the Security Rule. A covered entity must maintain, until six years after the later of the date of their creation or last effective date, written security policies and procedures and written records of required actions, activities or assessments.30

• **Updates.** A covered entity must periodically review and update its documentation in response to environmental or organizational changes that affect the security of electronic protected health information (e-PHI).31

**State Law**

• **Preemption.** In general, State laws that are contrary to the HIPAA regulations are preempted by the federal requirements, which means that the federal requirements will apply.32 “Contrary” means that it would be impossible for a covered entity to comply with both the State and federal requirements, or that the provision of State law is an obstacle to accomplishing the full purposes and objectives of the Administrative Simplification provisions of HIPAA.33

**Enforcement and Penalties for Noncompliance**

• **Compliance.** The Security Rule establishes a set of national standards for confidentiality, integrity and availability of e-PHI. The Department of Health and Human Services (HHS), Office for Civil Rights (OCR) is responsible for administering and enforcing these standards, in concert with its enforcement of the Privacy Rule, and may conduct complaint investigations and compliance reviews.

• Learn more about enforcement and penalties in the Privacy Rule Summary - PDF - PDF and on OCR’s Enforcement Rule page.

**Compliance Dates**

• **Compliance Schedule.** All covered entities, except “small health plans,” must have been compliant with the Security Rule by April 20, 2005. Small health plans had until April 20, 2006 to comply.

**Copies of the Rule and Related Materials**

• See our Combined Regulation Text of All Rules section of our site for the full suite of HIPAA Administrative Simplification Regulations and HIPAA for Professionals for additional guidance material.

**End Notes**


[13] 45 C.F.R. § 164.306(e); 45 C.F.R. § 164.308(a)(8).


[22] 45 C.F.R. §§ 164.310(b) & (c).

[23] 45 C.F.R. § 164.310(d).


[26] 45 C.F.R. § 164.312(c).

[27] 45 C.F.R. § 164.312(e).


