

<b>STATE OF ALASKA</b> <b>DEPARTMENT OF HEALTH &amp; SOCIAL SERVICES</b>  <b>SENIOR AND DISABILITIES SERVICES</b>  <b>POLICY &amp; PROCEDURE MANUAL</b>	<b>SECTION:</b> Personal Care Services	<b>Number:</b> 10-13	<b>Page:</b> 1
	<b>SUBJECT:</b> Service Plan Amendments		
	<b>APPROVED:</b> <i>/s/ Duane G. Mayes</i> Duane G. Mayes, Director		<b>DATE:</b> 11/20/14
	<b>Effective</b> November 24, 2014		

## Purpose

- To provide a standardized process for requesting amendments to service plans.
- To describe the circumstances that warrant amendment requests.
- To clarify requirements for documentation of the need for service plan amendments.

## Policy

Personal care services agencies are required to report changes that could affect a recipient's Personal Care Services (PCS) service level authorization. Based on the reported changes, a recipient's services may be increased, reduced, or terminated.

Agencies may request amendment of a service plan when a recipient experiences a material change. Provider agencies must submit an amendment request that indicates the activities of daily living (ADLs), instrumental activities of daily living (IADLs) and other covered activities for which an adjustment is warranted, and must document the need for an adjustment to those activities with medical records or other relevant information. The provider may request an expedited review in specified circumstances.

SDS will review a request for an amendment that documents a material change involving a recipient's medical condition; functional capacity; living environment; or paid or unpaid supports, caregivers, or services. If the changes are so significant that reevaluation of the recipient's condition is necessary, SDS will arrange for an expedited assessment before making a determination regarding the amendment request.

SDS will authorize an increase in relevant activities only when the frequency, scope, and length of those activities are supported through documentation of need based on the recipient's changed circumstances. SDS will deny an amendment request that is insufficiently documented or not supported, and may reduce services when the documentation submitted points to a decreased need for assistance with activities.

## Authority

7 AAC 125.026 Changes in personal care services level authorization; 7 AAC 125.028 Reporting changes; 7 AAC 125.180 Review and appeal rights.

## Responsibilities

- A. The **personal care services agency** is responsible for:
1. reporting changes related to the recipient's need for personal care services;
  2. consulting the recipient's care coordinator if the adjustments requested would duplicate or replace approved waiver services;
  3. identifying and obtaining medical documentation or other relevant information to support the request; and
  4. submitting an amendment request with supporting documentation.

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**B. SDS is responsible for:**

1. reviewing the amendment request and supporting documentation;
2. approving or denying the request, in whole or in part;
3. revising the Service Level Authorization, and
4. notifying the recipient/legal representative and the personal care services agency regarding approval or denial of the request.

**Procedures**

**A. Basis for amendment of PCS services level authorizations: qualifying circumstances**

1. Amendment requests. SDS will consider, in whole or in part, an amendment request that demonstrates a material change in the recipient's
  - a. medical condition or functional capacity;
  - b. physical living environment;
  - c. unpaid supports, caregivers, or services; or
  - d. paid supports, caregivers, or services.
2. Expedited requests. SDS will conduct an expedited review of an amendment request when the recipient has no natural supports able to meet his/her needs, and the recipient qualifies because of
  - a. a diagnosis of terminal illness with a life expectancy of six months or less;
  - b. the imminent or recent discharge (not more than seven days after discharge) from an acute care or nursing facility;
  - c. an unplanned absence of a primary unpaid caregiver due to a medical/family emergency or hospitalization;
  - d. the declining health of the primary caregiver that makes him/her unable to continue to provide care for the recipient;
  - e. the death of the primary unpaid caregiver;
  - f. a referral by Adult Protective Services or the Office of Children's Services; or
  - g. a request by the personal care services agency for a time-limited increase in services, not to exceed six consecutive weeks, to address a recipient's immediate medical or functional capacity need.

**B. Required documentation**

1. Required documentation for a change in the recipient's medical condition or functional capacity:
  - a. clinical records or other relevant information from the recipient's current health care providers that verify the change, and, separately or together, support an adjustment to the recipient's personal care services; the records must show
    - i. the date the recipient was evaluated, and
    - ii. the change in condition or diagnosis that is consistent with the activities, and the frequency, scope, and length of time for the ADLs, IADLs, or other services requiring adjustments to the service plan;
  - b. a *Request for Prescribed Personal Care Activities* form (Attachment C) for an amendment request for prescribed passive range of motion exercises, walking exercise, or foot care;

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2. Required documentation for a change in the recipient's physical living environment:  
information that supports an adjustment to the recipient's personal care services, including:
  - a. the date of the change;
  - b. description of the change and the impact of the change on the recipient that is consistent with the activities, and the frequency, scope, and length of time for the ADLs, IADLs, or other services requiring adjustments to the service plan.
3. Required documentation for a change in unpaid supports, caregivers, or services:  
information that supports the need for an adjustment to the recipient's personal care services, including:
  - a. the date of the change;
  - b. description of the change and the impact of the change on the recipient that is consistent with the activities, and the frequency, scope, and length of time for the ADLs, IADLs, or other services requiring adjustments to the service plan; and
  - c. for an individual with legal responsibility to provide care for the recipient, a statement from the individual's physician that the individual is no longer capable of performing IADLs for the recipient.
4. Required documentation for a change in paid supports, caregivers, or services:  
information that supports the need for an adjustment to the recipient's personal care services, including:
  - a. the date of the change;
  - b. description of the change and the impact of the change on the recipient that is consistent with the activities, and the frequency, scope, and length of time for the ADLs, IADLs, or other services requiring adjustments to the service plan.

### **C. Amendment process**

#### 1. Initiating the process.

The PCS agency representative

- a. reports changes as required by 7 AAC 125.028 on the *Amendment to Service Plan* form (Attachment A);
- b. contacts the following individuals to discuss whether a change in the recipient's condition supports an adjustment to the recipient's personal care services:
  - i. the recipient/legal representative, and
  - ii. the recipient's care coordinator, if the recipient receives both personal care services and home and community-based services;
- c. if applicable, verifies that
  - i. the recipient chooses to adjust personal care services rather than home and community-based services; and
  - ii. the recipient's care coordinator has submitted an amendment to the recipient's waiver plan that corresponds to the personal care services amendment request;
- d. signs the amendment request form, and obtains the signature of
  - i. the recipient/legal representative, and
  - ii. the care coordinator, when the adjustments requested would duplicate or replace services approved in the recipient's approved home and community-based waiver service plan; and

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- e. submits
  - i. an *Amendment to Service Plan* form that describes the recipient's change in condition, and the specific activities, and the adjustments to frequency, scope, and length of time warranted by the change;
  - ii. a *Request for Expedited Consideration* (Attachment B) when qualifying circumstances exist; and
  - iii. documentation that supports the adjustments to personal care services.

2. SDS review.

SDS reviews the amendment request and documentation, and

- a. for requests with administrative insufficiencies, sends a courtesy notice to providers requesting that corrections be made in five business days;
- b. for requests with all documentation and signatures necessary to make a decision,
  - i. approves the request, in whole or in part, if supported by the documentation submitted, or
  - ii. denies the request if not supported by the documentation;
- c. for requests with insufficient documentation, denies the request; and
- d. for requests based on changes so significant that a reevaluation of the recipient's condition is necessary, arranges for an expedited assessment.

3. Service plan adjustments.

SDS adjusts the service level authorization when the amendment request is supported for the duration of the authorized service plan or for a period of time appropriate to the recipient's condition.

4. Notice.

- a. SDS notifies the recipient/legal representative and the PCS agency of the decision regarding the amendment request
  - i. within 30 business days of receipt of a fully-documented request; and
  - ii. within ten business days of receipt of an expedited request, whether or not an expedited assessment is scheduled.
- b. SDS notice includes the following:
  - i. for approvals,
    - A) letter approving, in whole or in part, the amendment request;
    - B) *Amendment Service Level Authorization Chart*;
    - C) *Notice of Recipient Fair Hearing Rights*
  - ii. for denials,
    - A) letter denying the amendment request; and
    - B) *Notice of Recipient Fair Hearing Rights*

**Attachments**

Attachment A: *Amendment to Service Plan*

Attachment B: *Request for Expedited Consideration*

Attachment C: *Request for Prescribed Personal Care Activities*



## Personal Care Services Amendment to Service Plan

Recipient name

Medicaid number

Agency name

Provider number

Agency contact

Contact telephone number

Agency FAX number

### Basis for this amendment request

The recipient has experienced a material change in his/her

- medical condition or functional capacity
- physical living environment
- unpaid supports, caregivers, or services
- paid supports, caregivers, or services

### Requested adjustments to the Service Level Authorization

Specify the activity, and the frequency, scope, and length of time for each activity, to be adjusted because of the change in the recipient's condition.

Activity	Frequency <i>Times per day</i>	Scope <i>Times per week</i>	Length <i>How long needed</i>

### Description of changes

Date of the change

Describe the change.

For each activity listed, describe how the requested adjustments to frequency, scope, and length are necessary because of the material change.

### Required documentation

Attach documentation that supports the specific adjustments to the Service Level Authorization as required by *Personal Care Services Policy and Procedures 10-13*.

**Recipient Assurances**

*I acknowledge the change described in this request for amendment of my Personal Care Services service level authorization, and the impact of that change on my life. I have participated in the planning of my care, and agree that the adjustments in activities are related to the described change and are appropriate for my care. I request amendment of my Service Level Authorization as indicated in the activities table.*

*I understand that this is an application for Medicaid benefits, and that any misrepresentation, omission, or concealment of a material fact may subject me to civil monetary penalties, fines, or criminal prosecution. I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.*

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 Recipient/Legal representative signature

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 Date

If the recipient signs with an “X”, the signature of a witness who is not the recipient’s care coordinator, personal care assistant, or representative of the personal care services agency is required.

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 Witness signature

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 Date

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 Witness printed name

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 Date
**Care Coordinator Assurances** (To be signed if the recipient receives Home and Community-based Services)

*I acknowledge that the change described in this request for amendment has impacted the life of the recipient, and that the recipient has chosen to adjust Personal Care Services rather than Home and Community-based Services to address needs brought about by the change. I have submitted a request to amend the recipient’s Plan of Care that corresponds to this request to amend the recipient’s Service Level Authorization*

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 Care coordinator signature

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 Date
**Agency assurances**

*I certify that the adjustments indicated in the activities table are necessary because of the described material change in the named recipient’s condition and the impact of that change on the recipient’s life.*

*I understand that this is an application for Medicaid benefits, and that any misrepresentation, omission, or concealment of a material fact may subject me to civil monetary penalties, fines, or criminal prosecution. I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.*

---

 Agency representative signature

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 Date



## Home and Community-Based Services • Personal Care Services

### Request for Expedited Consideration

#### Applicant/Recipient

Name

Medicaid number

Describe the change and the impact of the material change on the recipient resulting in the need for an amendment of the service plan.

This request is for an  Initial application/assessment  Amendment of current service plan

for the following program:  IDD  CCMC  APDD  ALI  PCS  LTC

For an initial application, provide the address of the location where an assessment can be performed:

#### Basis for expedited consideration

The recipient has no natural supports able to meet his /her needs, and qualifies for expedited consideration because of

- a diagnosis of terminal illness with a life expectancy of six months or less
- imminent/recent discharge on \_\_\_\_\_ from an acute care or nursing facility
- unplanned absence of primary unpaid caregiver due to medical/family emergency or hospitalization
- declining health of his/her primary unpaid caregiver
- the death of his/her primary unpaid caregiver on \_\_\_\_\_
- Adult Protective Services/Office of Children's Services referral

For Personal Care Services only

- a need for a time-limited increase in services to address immediate medical/functional need

#### Required documentation

Attach documentation that supports expedited consideration.

Describe the circumstances that qualify the applicant/recipient for expedited consideration.

#### Provider agency requesting expedited consideration

Agency name

Provider number

Agency contact

Telephone number

DSM/encrypted Email address

Agency FAX number

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 Agency representative signature

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 Date

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 For SDS use only      Date of review \_\_\_\_\_ Request  approved  denied

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 Reason for decision \_\_\_\_\_

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 Follow-up on \_\_\_\_\_ Purpose \_\_\_\_\_

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 SDS reviewer signature

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 Date



## Personal Care Services Request for Prescribed Personal Care Activities

Patient name \_\_\_\_\_ Medicaid number \_\_\_\_\_

Date of patient's most recent visit \_\_\_\_\_

Personal Care Services may be authorized for Medicaid recipients who need physical assistance with basic personal activities and other activities related to independent living. The activities listed on the table below, often called "prescribed tasks", require a prescription and medical documentation from a medical professional.

Your recommendation for these activities must be based on personal knowledge of your patient's medical or functional condition; consequently, you should not sign a form pre-filled by a Personal Care Services agency. Please indicate, for each activity you recommend, the number of times a day and per week and for how long (not to exceed one year) the activity should be provided, and how long the activity should last (do not use ranges) each time it is provided. Attach medical documentation that will support your recommendation.

Activity requiring a prescription	Frequency Times per day	Scope Times per week	Duration Time per activity	Length How long needed
Passive range of motion exercises	<i>Recommend only when direct physical assistance is required to perform ROM; ROM exercise plan required. Attach plan to this form.</i>			
Walking exercise	<i>Recommend only when direct physical assistance is required to enable walking.</i>			
Foot care	<i>Recommend only when a medical condition justifies foot care in addition to that performed during the time allowed for bathing and personal hygiene. (Personal care assistants may not provide foot care for diabetics.)</i>			

### Prescriber assurances

*I understand that, although I may recommend activities, the decision to authorize them will be made by Senior and Disabilities Services on the basis of a review of current medical documentation and a functional assessment of the patient's capacity to perform the activities. I recommend the listed Personal Care Services activities for the named patient based on personal knowledge of his/her medical or functional condition, and have attached medical documentation supporting the need for assistance with those activities.*

*I understand that this is an application for Medicaid benefits, and that any misrepresentation, omission, or concealment of a material fact may subject me to civil monetary penalties, fines, or criminal prosecution. I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.*

\_\_\_\_\_  
Prescriber signature

\_\_\_\_\_  
Date

MD  DO  PA  ANP

\_\_\_\_\_  
Prescriber printed name

\_\_\_\_\_  
Prescriber telephone number

\_\_\_\_\_  
Medicaid ID or AK license number