

PERSONAL CARE AGENCY SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenen provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the [provider enrollment chart](#) for additional details on enrollment eligibility and supporting documentation requirement.

Personal Care Agencies must meet additional Department of Human Services Division of Long Term Serviced and Supports (LTSS) requirements which include:

- Completing a Quality Management Self-Assessment;
- Undergoing an onsite review and successfully completing any corrective actions necessary;
- Signing a Purchases of Services Agreement between LTSS and the provider.

Providers must also set up an account in LTSS' case management system, Therap, in order to receive and acknowledge referrals for personal care services.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's [online portal](#).

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

| Coverage Type | Coverage Limitations |
|-----------------------------|--|
| Medicaid/CHIP Full Coverage | Medically necessary services covered in accordance with the limitations described in this chapter. |

Refer to the [Recipient Eligibility](#) manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles

Providers should refer to the [General Coverage Principles](#) manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and

- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Needs Assessment

In order for a recipient to receive personal care services, the recipient must have an assessment to determine his or her need for personal care services. The needs assessment is conducted by the Department of Human Services, Division of Long Term Services and Supports (LTSS). The needs assessment is based on information provided by the individual in the following areas:

- Cognition;
- Communication and vision;
- Mood and behavior;
- Psychosocial well-being;
- Functional status;
- Continence;
- Disease and diagnoses;
- Health conditions;
- Oral and nutritional status;
- Skin condition;
- Medications;
- Treatment and procedures;
- Social supports; and
- Environment.

LTSS encourages providers to review [SDCL Ch. 36-9](#) to determine when authorized services must be delivered by a licensed nurse.

Service Plan

LTSS develops a service plan for each individual eligible for personal care services. The plan is based on the individual's needs assessment and contains items such as the following:

- The reason for the service request;
- The number of personal care service hours assigned to the individual;
- The personal care services needed; and
- The individual's responsibilities.

Covered Personal Care Services

Personal care services are limited to medically necessary services contained in the recipient's service plan and provided in a home or community based location. Personal care services covered are limited to the following:

- Basic personal care and grooming, including bathing, shaving, dressing, and assisting the recipient with hair and teeth care;
- Assistance with bladder or bowel requirements, which does not include administration of a bowel program;

- Assisting the patient with medications which are ordinarily self-administered;
- Assistance with food, nutrition, and diet activities if they are incidental to a medical need;
- Performing those household services, if related to a medical need, that are essential to the patient's health and comfort in the patient's residence; or
- Maintenance nursing prescribed by a physician.

A home or community based location does not include a hospital, penal institution, detention center, school, nursing facility, assisted living center, congregate facility where services are available, other types of group settings, intermediate care facility for individuals with intellectual disabilities, or an institution which treats individuals for mental diseases.

Hours Limitation

A recipient is limited to 500 hours of agency based personal care services in a plan year (July 1 – June 30). This limit does not apply to recipients age 20 or younger. If a recipient is eligible for a home and community-based services waiver and has an assessed need for more than 500 hours, additional units may be authorized under the applicable waiver program.

Discontinuance of Services

LTSS may discontinue personal care agency services for a recipient when the cost of providing care exceeds the cost of institutional care, the recipient can no longer benefit from the services provided, or the recipient's or the provider's health or safety would be jeopardized if the services were continued. When LTSS determines that services to a recipient must be discontinued, the provider will be notified as soon as possible.

The provider must have a policy for discharge of recipients that are determined ineligible or the provider can no longer serve. When a provider determines services to a recipient must be discontinued by their agency, the provider must notify LTSS at least 30 days before the recipient is discharged, unless the recipient's home constitutes an unsafe environment for provider staff and/or the recipient. The notice must be in writing and must specify the reason for discharge in accordance with the provider's discharge policy. Specific reasons for discontinuing services include the following:

- The recipient's medical needs may require daily nursing. Indications are the recipient is experiencing falls, is failing to take needed medication, is suffering from uncontrolled tuberculosis or antibiotic-resistant organisms, or two people are needed to move the recipient;
- The recipient is sexually harassing, verbally abusive, threatening, or combative towards the person delivering services;
- The recipient's care plan exceeds the limits of the in-home care limits;
- The recipient's living environment presents health and fire hazards or unsafe conditions for the person delivering services;
- The recipient's family and individuals from other support systems have discontinued providing care or are unable to provide the care needed;
- The recipient is not in compliance with the case service plan;
- The recipient's cognitive ability is limited to the extent that the recipient is not oriented to person, place, or time;
- The recipient is not capable of self-preservation in an emergency;

- The recipient's condition has improved and no longer meets program eligibility;
- The recipient failed to contribute to the program as required;
- The recipient refuses to allow the service provider on the premises;
- The recipient or others in the household are under the influence of drugs or alcohol; or
- The recipient has pornographic materials exhibited in the home.

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to [ARSD 67:16:01:08](#) or the [General Coverage Principles](#) manual for a general list of services that are not covered by South Dakota Medicaid.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the [Documentation and Record Keeping](#) manual for additional requirements.

Electronic Visit Verification (EVV) Requirements

Personal Care Services must comply with federal Electronic Visit Verification (EVV) requirements. Provider's may utilize the State's EVV system. There is no cost to the provider to utilize the State's system. If the provider determines utilization of the State's EVV system is not feasible, the provider may complete the Provider Request for Approval for Alternative IT System for Electronic Visit Verification (EVV) form. Email Misty Black Bear at Misty.BlackBear@state.sd.us to obtain the form. If an alternative IT system is approved, the provider must ensure the minimum EVV requirements are met. EVV requirements include the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers. Providers must pursue the availability of third-party payment

sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Reimbursement

Payment for services will be the lower of the provider's usual and customary charge or the rate listed on the Personal Care Agency [fee schedule](#).

Claim Instructions

Services must be billed on a CMS 1500 claim form or via an 837P electronic transaction. Refer to our [website](#) for detailed billing instructions. A provider must submit claims at the provider's usual and customary charge.

HCPCS

Services should be billed for using the applicable HCPCS code list below:

- S5130 – Homemaker services
- T1019 – Personal care services
- T1000 – Maintenance nursing

DEFINITIONS

1. "Activities of daily living," tasks performed routinely by a person to maintain physical functioning and personal care, including transferring, moving about, dressing, grooming, toileting, and eating;
2. "Economic resources," the recipient's own resources together with other types of assistance, financial or otherwise, which are available to a recipient and would help maintain the recipient in the recipient's own home;
3. "Maintenance nursing," periodic evaluation and counseling by a licensed nurse to promote and maintain the individual's optimal health. Maintenance nursing may include injections, monitoring and setting up medications, physical assessments, monitoring patient status, foot care, drawing blood, changing dressing, and health education;
4. "Personal adjustment," the mental or emotional state of well-being of a recipient on a continuum from good to poor. Poor personal adjustment may include problems with sleeping, difficulty in expressing feelings, unhappiness, or depression;
5. "Personal care provider," an agency incorporated in South Dakota which has a contract with the department to provide personal care services in the recipient's place of residence;
6. "Personal care services," medically necessary services in the recipient's case service plan described in [ARSD 67:16:24:03.03](#) that are provided by an individual who is qualified to provide the services and is not a member of the recipient's family;

7. "Physical environment," the recipient's dwelling unit, building, or house and its furnishings and the neighborhood in which the recipient resides;
8. "Physical health," the medical state of well-being which may be on a continuum from good to poor. Poor health is the presence of one or more illnesses or physical disabilities which are either painful or inhibit a person's ability to perform daily tasks; and
9. "Social resources," support or assistance available to a recipient from the recipient's family, friends, neighbors, or community organizations such as churches, civic groups, or senior centers or other agencies providing services to residents of the community.

REFERENCES

- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

QUICK ANSWERS

1. What happens if the recipient has reached the 500-hour limit and still needs services?

The provider and/or recipient may contact Dakota at Home at 1-833-663-9673 to determine if additional services may be authorized.

2. Can an individual on the CHOICES or Family Support 360 waiver receive personal care services through this program?

An individual on the CHOICES or Family Support waivers may receive Personal Care Services if it is deemed appropriate by the Waiver Operations staff within the Division of Development Disabilities. Referrals should be made through Dakota at Home.

3. Is maintenance nursing subject to EVV requirements?

Yes, maintenance nursing provided though the personal care services benefit is subject to EVV requirements.