PERSONAL ASSISTANCE PROTOCOL

A. *Initial* Personal Assistance

(NOTE: This section applies to service recipients who are **not** currently approved for Personal Assistance through the waiver.

1. Is the service recipient a minor (i.e., under age 18 years)?

   If **YES**, proceed to Question #2.

   If **NO**, skip to Question #3.

2. Will Personal Assistance be provided by the service recipient's parent (whether the relationship is by blood, by marriage, or by adoption)?

   If **YES**, stop and deny as a **non-covered service** based on the waiver service definition. Include the following statement in the denial notice: "The waiver says we can't pay the parent to provide care for a minor child." Include the following citation for the applicable waiver:

   - "Statewide waiver," waiver #0128.90.R2A.02, page B-25
   - "Arlington waiver," waiver #0357.90.02, page B-25
   - "Self-Determination waiver," waiver #0427.02, page B-5

   If **NO**, proceed to Question #3.

3. Will Personal Assistance be provided by the service recipient's spouse?

   If **YES**, stop and deny as a **non-covered service** based on the waiver service definition. Include the following statement in the denial notice: "The waiver says we can't pay the husband or wife to provide care for the spouse." Include the following citation for the applicable waiver:

   - "Statewide waiver," waiver #0128.90.R2A.02, page B-25
   - "Arlington waiver," waiver #0357.90.02, page B-25
   - "Self-Determination waiver," waiver #0427.02, page B-5

   If **NO**, proceed to Question #4.

4. Is Personal Assistance being requested for one of the following reasons which are specifically *excluded* in the waiver service definition:

   a. To transport or otherwise take children to and from school; **OR**

   b. To provide Personal Assistance in school settings; **OR**

   c. To provide Personal Assistance to a service recipient who receives a residential Service (i.e., Residential Habilitation, Supported Living, Medical Residential Services, or Family Model Residential Support); **OR**

   d. To provide Personal Assistance during the time period when the service recipient is receiving a Day Service?

   If **YES**, stop and deny that portion of the requested Personal Assistance that is attributable to the excluded services as **non-covered** based on the waiver service definition. If only part of the request was denied as non-covered, proceed to Question #5.

   If **NO**, proceed to Question #5.

5. Medical necessity review questions:

   a. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient has:

      (1) Functional limitations that justify the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, feeding/assistance with eating, toileting and incontinence care, assistance with transfer and mobility) or instrumental activities of daily living (e.g., meal preparation, household chores, budget management, and accompaniment to medical appointments or on personal errands); **OR**

      (2) Aggressive or inappropriate behavior that jeopardizes the health and safety of the service recipient or others and requires supervision and intervention; **AND**

   b. Does the ISP and/or supporting documentation identify the specific types of direct assistance needed with activities of daily living and instrumental activities of daily living and, if applicable, the behavioral supervision and/or intervention (either with or without a Behavior Support Plan) that the Personal Assistant will provide to ensure the service recipient's safety **AND**

   c. Is there sufficient information in the ISP and/or supporting documentation to show that the amount of requested Personal Assistance services requested will not replace uncompensated care that is the responsibility of the primary caregiver and that could reasonably and appropriately be provided by the primary caregiver or other unpaid caregivers to meet the needs of the service recipient; **AND**

   d. Is there **no other caregiver available** during the time that Personal Assistance is requested, including a caregiver who may be authorized to provide a different level of assistance, such as a registered nurse or licensed practical nurse?

      NOTE: Except under *exceptional circumstances*, two Personal Assistants may **not** be authorized or reimbursed to provide Personal Assistance services to the same service recipient during the same period of time. If exceptional circumstances are warranted and approved by the DMRS Central Office, reimbursement will be made using a special 2-person reimbursement rate only (i.e., service units may not be approved and billed separately for each Personal Assistant providing services during the same time period.)

      Except under *exceptional circumstances*, Personal Assistance may **not** be authorized or reimbursed *at the same time* as:

(1) **Waiver** Nursing Services;
(2) **TennCare** Private Duty Nursing;
(3) **TennCare** Home Health Skilled Nursing Services;
(4) **TennCare** Home Health Aide Services; or
(5) **TennCare** EPSDT Personal Care services.

Any request for exception must be submitted *in writing* to the DMRS Central Office and must specify:

- The total number of hours of *each* type of service requested (i.e., Personal Assistance, **waiver** Nursing Services, **TennCare** Private Duty Nursing, **TennCare** Home Health Skilled Nursing Services, **TennCare** Home Health Aide Services, or **TennCare** EPSDT Personal Care services);
- The service recipient's medical condition(s), diagnoses, and/or disabilities that creates the need for such services;
- The specific skilled nursing functions to be performed and the frequency such skilled nursing functions are requested (as applicable);
- The specific functions or tasks each Personal Assistant, Personal Care staff, and/or Home Health Aide is expected to perform, including the frequency with which each task must be performed; and
- A schedule of how such services will be coordinated that clearly demonstrates the total amount of time during which the service recipient will be receiving more than one (1) such service *at the same time*.

DMRS must provide to the TennCare Division of Long Term Care a copy of all information pertaining to all such authorization approvals.

If **YES** ***to all four*** of the criteria specified in "5.a" through "5.d" above, proceed to Question #6.

If **NO to any of the criteria specified** in "5.a" through "5.d" above, stop and deny as **not medically necessary**. All of the unmet medical necessity criteria from "5.a" through "5.d" above and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

6. Is the frequency (per day, per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of Personal Assistance requested *consistent with* and not *in excess of* the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b" above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety?

   If **YES**, proceed to Question #7.

   If **NO**, deny as **not medically necessary** that portion of the total amount of Personal Assistance requested that is *in excess of* the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b" above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety. The unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

   - "Not necessary to treat;"

- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

AND, proceed to Question #7 to determine coverage of that portion of the total amount of Personal Assistance requested that is *consistent with* the amount of Personal Assistance to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b" above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety.

7. Is the service recipient age 21 years or older?

   If **YES**, stop and approve (as determined in Question #6 above) that portion of the total amount of Personal Assistance requested that is *consistent with* the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b" above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety.

   If **NO**, proceed to Question #8.

8. Is the request for Personal Assistance based *only* on the service recipient's need for direct hands-on assistance with activities of daily living (instead of a need for behavioral supervision and intervention or assistance with household chores)?

   If **YES**, proceed to Question #9.

   If **NO**, stop and approve (as determined in Question #6 above) that portion of the total amount of Personal Assistance requested that is *consistent with* the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b" above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety.

9. Was a request submitted to the TennCare Managed Care Organization (MCO) for "Home Health Aide Services" (hands on care of the service recipient which is provided in the home by a licensed Home Health Agency) and/or for "Personal Care Services" (hands on care of the service recipient which may be provided by a licensed Home Health Agency for children under age 21 outside the home as a TennCare EPSDT benefit), as applicable, and denied through the TennCare MCO fair hearing process?

   If **YES**, approve (as determined in Question #6 above) that portion of the total amount of Personal Assistance requested that is *consistent with* the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b" above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety

   If **NO**, deny Personal Assistance based on the waiver being the **payor of last resort**. Include the following statement in the denial letter: "The kind of care you need is hands on care. That kind of medically necessary care can be covered under the TennCare Program as Home Health Aide services or Personal Care services for children under age 21. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]."

B. *Continuation* of Personal Assistance

(NOTE: This section applies to service recipients who are *currently* approved for Personal Assistance through the waiver and who request *continuation* of Personal Assistance or an *increase* in Personal Assistance.)

1. Is the service recipient a minor (i.e., under age 18 years)?

   If **YES**, proceed to Question #2.

   If **NO**, skip to Question #3

2. Will Personal Assistance be provided by the service recipient's parent (whether the relationship is by blood, by marriage, or by adoption)?

   If **YES**, stop and deny as a **non-covered service** based on the waiver service definition. Include the following statement in the denial notice: "The waiver says we can't pay the parent to provide care for a minor child." Include the following citation for the applicable waiver:

   - "Statewide waiver," waiver #0128.90.R2A.02, page B-25
   - "Arlington waiver," waiver #0357.90.02, page B-25
   - "Self-Determination waiver," waiver #0427.02, page B-5

   If **NO**, proceed to Question #3.

   If previously approved Personal Assistance services are reduced or terminated (including on the grounds that such service is non-covered based on the waiver service definition), issue 20 days advance notice (inclusive of mail time) of reduction or termination of services, as applicable, indicating that the services will be reduced or terminated on the 21st day from the date of the notice. The previously approved Personal Assistance services shall continue to be authorized and reimbursed pending such advance notice period.

   The service recipient may file a timely appeal regarding the reduction/termination of Personal Assistance services within 40 days from the date of the notice (inclusive of mail time) or *any time prior* to the effective date of the action (i.e., the date the services are reduced or terminated).

   If an appeal is received within 20 days from the date of notice (inclusive of mail time), or *any time prior* to the effective date of the action, the service recipient may request continuation of previously approved Personal Assistance services pending resolution of the appeal. However, continuation of benefits is **not available** for a non-covered service, including a request that is beyond the scope of the waiver service definition, and accordingly, may not be granted.

   NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

3. Will Personal Assistance be provided by the service recipient's spouse?

   If **YES**, stop and deny as a **non-covered service** based on the waiver service definition. Include the following statement in the denial notice: "The waiver says we can't pay the husband or wife to provide care for the spouse." Include the following citation for the applicable waiver:

- "Statewide waiver," waiver #0128.90.R2A.02, page B-25
- "Arlington waiver," waiver #0357.90.02, page B-25
- "Self-Determination waiver," waiver #0427.02, page B-5

If **NO**, proceed to Question #4.

If previously approved Personal Assistance services are reduced or terminated (including on the grounds that such service is non-covered based on the waiver service definition), issue 20 days advance notice (inclusive of mail time) of reduction or termination of services, as applicable, indicating that the services will be reduced or terminated on the 21st day from the date of the notice. The previously approved Personal Assistance services shall continue to be authorized and reimbursed pending such advance notice period.

The service recipient may file a timely appeal regarding the reduction/termination of Personal Assistance services within 40 days from the date of the notice (inclusive of mail time) or *any time prior* to the effective date of the action (i.e., the date the services are reduced or terminated).

If an appeal is received within 20 days from the date of notice (inclusive of mail time), or *any time prior* to the effective date of the action, the service recipient may request continuation of previously approved Personal Assistance services pending resolution of the appeal. However, continuation of benefits is **not available** for a non-covered service, including a request that is beyond the scope of the waiver service definition, and accordingly, may not be granted.

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

4. Is *continuation* of Personal Assistance services being requested for one of the following reasons which are specifically *excluded* in the waiver service definition:

   a. To transport or otherwise take children to and from school; **OR**

   b. To provide Personal Assistance in school settings; **OR**

   c. To provide Personal Assistance to a service recipient who receives a residential Service (i.e., Residential Habilitation, Supported Living, Medical Residential Services, or Family Model Residential Support); **OR**

   d. To provide Personal Assistance during the time period when the service recipient is receiving a Day Service?

If **YES**, stop and deny *continuation* of that portion of the requested Personal Assistance that is attributable to the excluded services as **non-covered** based on the waiver service definition. If only part of the request was denied as non-covered, proceed to Question #5.

If previously approved Personal Assistance services are reduced or terminated (including on the grounds that such service is non-covered based on the waiver service definition), issue 20 days advance notice (inclusive of mail time) of reduction or termination of services, as applicable, indicating that the services will be reduced or terminated on the 21st day from the date of the notice. The previously approved Personal Assistance services shall continue to be authorized and reimbursed pending such advance notice period.

The service recipient may file a timely appeal regarding the reduction/termination of Personal Assistance services within 40 days from the date of the notice (inclusive of mail time) or *any time prior* to the effective date of the action (i.e., the date the services are reduced or terminated).

If an appeal is received within 20 days from the date of notice (inclusive of mail time), or *any time prior* to the effective date of the action, the service recipient may request continuation of previously approved Personal Assistance services pending resolution of the appeal. However, continuation of benefits is **not available** for a non-covered service, including a request that is beyond the scope of the waiver service definition, and accordingly, may not be granted.

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

If **NO**, proceed to Question #5.

5. Medical necessity review questions:

   a. Is there sufficient information in the Individual Support Plan (ISP) and/or supporting documentation to show that the service recipient *continues* to have:

      (1) Functional limitations that justify the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, feeding/assistance with eating, toileting and incontinence care, assistance with transfer and mobility) or instrumental activities of daily living (e.g., meal preparation, household chores, budget management, and accompaniment to medical appointments or on personal errands); **OR**

      (2) Aggressive or inappropriate behavior that jeopardizes the health and safety of the service recipient or others and requires supervision and intervention; **AND**

   b. Does the ISP and/or supporting documentation identify the specific types of direct assistance needed with activities of daily living and instrumental activities of daily living and, if applicable, the behavioral supervision and/or intervention (either with or without a Behavior Support Plan) that the Personal Assistant will provide to ensure the service recipient's safety **AND**

   c. Is there sufficient information in the ISP and/or supporting documentation to show that the amount of requested Personal Assistance services requested will not replace uncompensated care that is the responsibility of the primary caregiver and that could reasonably and appropriately be provided by the primary caregiver or other unpaid caregivers to meet the needs of the service recipient; **AND**

   d. Is there **no other caregiver available** during the time that Personal Assistance is requested, including a caregiver who may be authorized to provide a different level of assistance, such as a registered nurse or licensed practical nurse?

      NOTE: Except under *exceptional circumstances*, two Personal Assistants may **not** be authorized or reimbursed to provide Personal Assistance services to the same service recipient during the same period of time. If exceptional circumstances are warranted and approved by the DMRS Central Office, reimbursement will be made using a special 2-person reimbursement rate only (i.e., service units may not be approved and billed separately for each Personal Assistant providing services during the same time period.)

      Except under *exceptional circumstances*, Personal Assistance may **not** be authorized or reimbursed *at the same time* as:

      (1) **Waiver** Nursing Services;
      (2) **TennCare** Private Duty Nursing;
      (3) **TennCare** Home Health Skilled Nursing Services;
      (4) **TennCare** Home Health Aide Services; or
      (5) **TennCare** EPSDT Personal Care services.

Any request for exception must be submitted *in writing* to the DMRS Central Office and must specify:

- The total number of hours of *each* type of service requested (i.e., Personal Assistance, **waiver** Nursing Services, **TennCare** Private Duty Nursing, **TennCare** Home Health Skilled Nursing Services, **TennCare** Home Health Aide Services, or **TennCare** EPSDT Personal Care services);
- The service recipient's medical condition(s), diagnoses, and/or disabilities that creates the need for such services;
- The specific skilled nursing functions to be performed and the frequency such skilled nursing functions are requested (as applicable);
- The specific functions or tasks each Personal Assistant, Personal Care staff, and/or Home Health Aide is expected to perform, including the frequency with which each task must be performed; and
- A schedule of how such services will be coordinated that clearly demonstrates the total amount of time during which the service recipient will be receiving more than one (1) such service *at the same time*.

DMRS must provide to the TennCare Division of Long Term Care a copy of all information pertaining to all such authorization approvals.

If **YES** ***to all four*** of the criteria specified in "5.a" through "5.d" above, proceed to Question #6.

If **NO to any of the criteria specified** in "5.a" through "5.d" above, stop and deny as **not medically necessary**. All of the unmet medical necessity criteria from "5.a" through "5.d" above and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

If previously approved Personal Assistance services are reduced or terminated, issue 20 days advance notice (inclusive of mail time) of reduction or termination of services, as applicable, indicating that the services will be reduced or terminated on the 21st day from the date of the notice. The previously approved Personal Assistance services shall continue to be authorized and reimbursed pending such advance notice period.

The service recipient may file a timely appeal regarding the reduction/termination of Personal Assistance services within 40 days from the date of the notice (inclusive of mail time) or *any time prior* to the effective date of the action (i.e., the date the services are reduced or terminated).

If an appeal is received within 20 days from the date of notice (inclusive of mail time), or *any time prior* to the effective date of the action, the service recipient may request continuation of previously approved Personal Assistance services pending resolution of the appeal, in which case, such previously approved Personal Assistance services shall continue pending notification from TennCare that the appeal has been resolved and that continuation of benefits may be stopped.

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

6. Is the frequency (per day, per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of Personal Assistance requested still *consistent with* and not *in excess of* the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b" above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety?

To the extent that the request includes any increase in the frequency, amount, or duration of Personal Assistance services, is there sufficient information in the ISP and/or supporting documentation to demonstrate that the service recipient's needs have changed and/or the previously approved frequency, amount, or duration of Personal Assistance services is no longer sufficient to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b" above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety?

If **YES**, approve *continuation* of that portion of the total amount of Personal Assistance requested that is *consistent with* the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b" above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety.

If **NO**, deny as **not medically necessary** *continuation* of that portion of the total amount of Personal Assistance requested that is *in excess of* the amount of services needed to the amount of services needed to perform the specific functions or tasks the Personal Assistant is expected to perform as specified in "5.b above and to provide, if applicable, the type(s) and amount of behavioral supervision and/or intervention needed to ensure the service recipient's safety. The unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

If previously approved Personal Assistance services are reduced or terminated, issue 20 days advance notice (inclusive of mail time) of reduction or termination of services, as applicable, indicating that the services will be reduced or terminated on the 21st day from the date of the notice. The previously approved Personal Assistance services shall continue to be authorized and reimbursed pending such advance notice period.

The service recipient may file a timely appeal regarding the reduction/termination of Personal Assistance services within 40 days from the date of the notice (inclusive of mail time) or *any time prior* to the effective date of the action (i.e., the date the services are reduced or terminated).

If an appeal is received within 20 days from the date of notice (inclusive of mail time), or *any time prior* to the effective date of the action, the service recipient may request continuation of previously approved Personal Assistance services pending resolution of the appeal, in which case, such previously approved Personal Assistance services shall continue pending notification from TennCare that the appeal has been resolved and that continuation of benefits may be stopped.

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

If *continuation* of Personal Assistance is approved for a lesser duration of service than requested, include the following in the denial letter: "Based on the medical records we have now, we can only tell that you need this care for ___ days. We must see if the care we have approved helps you before we can decide if you need more care. What if you think you will need this care for *more* than ___ days? Before the ___ days are over, you can ask for more care. OR, if you think your *current* medical records already show that you will need the care for *more* than ___ days, you can appeal.